MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10073

24b. REGISTRAR'S SIGNATURE

arthur & House

24a. REC'D BY REGISTRAR

DATESTO

8 '59

Reg. Dist. No PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. COUNTY b. COUNTY MARYLAND St. Mary's Co. Carroll Maryland b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town) RURAL and give nearest town) Rural) Sykesville, Md. Waldorf d. NAME OF HOSPITAL (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES NO Springfield State Hospital Middle 4. DATE Month Type or print oma 8 Benjamin Abell 9 DEATH 19 6. COLOR OR RACE 7. MARRIED NEVER MARRIED IF UNDER 1 YEAR IF UNDER 24 HRS B. DATE OF BIRTH AGE (In years log Sirthday) Months Davs Hours 10-23-72 Male White WIDOWED P DIVORCED | yes 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) Maryland USA RXX kerenormu, nerkimene 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Mandy Dorsey Thomas Abell IS. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address unknown Hospital Records unknown 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART 1. DEATH WAS CAUSED BY: 10 hours Bfonchopneumonia IMMEDIATE CAUSE (o) 420.0 more than DUE TO 5 yrs. Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate more than DUE TO couse (a), stating the under-10 years. lying cause last. (c) Generalized arteriosclarosis CBS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION CHEEN IN PART II. WAS AUTOPSY BY ASSOCIATION WITH SENTER PERFORMED? YES NO brain disease, with psychotic reaction, plus pulmonary TBC.

200. ACCIDENT WAS UNDERLYING | 20b. DESCRIBE HOW INJURY OCCURRED. (Enfer nature of injury in Part I or Part II of item 18.)
OR CONTRIBUTING | CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, Day, Year 20f. (City or town) (County) (State) factory, street, affice bldg., etc.) Haur a. m. While Not while at work at wark 21. I certify that I ottended the deceased from August _____, 19_59,that I lost sow the deceased , and that death occurred at 5145 M, from the causes and on the date stated above. olive on 9-1-ADDRESS (Street, city or town, state) Springfield State Hospital ACTUAL SIGNATURE PHYSICIAN'S Walter Knopp, M.D. Sykesville, Maryland 220. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (Stote) REMOVAL (Specify) Medley's Neck. Md. Our Lady's Chapel Burial



VS A15 (4)

15M 10/57

23. FUNERAL DIRECTOR'S SIGNATURE

Clarke Mattingley Leonardtown, Maryland

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sion and completely filled in by The funeral director, abroad papers. Pages 1 and 2 should be filed with

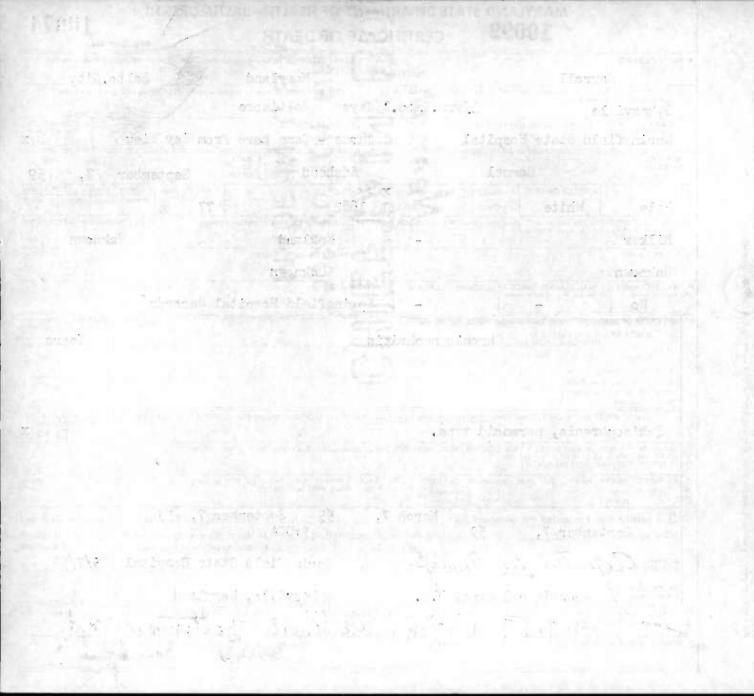
ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hau TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death of may be retained by the haspital or attending physician.

TO FUNERAL DYKECTOR: After this certificate has been signed by the attending page 3 shauld be detached for use as the burial-transit permit. Then please the registrar priar to burial, cremation, ar remayal, and in any event within 7

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 10099

CERTIFICATE OF DEATH

									Keg. Dis	it. No.		
1. PLACE OF DEATH				2. USUAL RE	SIDENCE (V	Vhere decea		If instituti	an: Residen	ce befor	e admis	sian)
	arroll		MARYLAND		Mary	land	0.	0001411	Balt	o. Ci	ty	V
b. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town)				. 11	R TOWN (If	outside car	porate limi	ts, write R	URAL and (give nea	rest taw	n)
Sykesvil			35yrs.9mos.15	days	Balt:	imore		31	101-	4		
d. NAME OF HOSPI	TAL (If not in hospital, g	ive street	address)	d. STREET	ADDRESS	here	from	Rav	View		ON	SIDENCE A FARM?
	.e.ta o da de 1	roppz		1-10120	Odine			Day	1 7611		162) NO [=
3. NAME OF DECEASED (Type or print)	Sa	muel	Middle	Adshe	ad	4. DATE OF DEAT		Sept	ember	Da		Year 1959
5. SEX	6. COLOR OR RACE	7. MAR	RIED NEVER MARRIED	B. DATE OF BI	RTH		9. AGE	(In years	IF UNDER	_	IF UND	ER 24 HRS
Male	White	WIDOW	ED DIVORCED	1882			77	oirthday) yrs.	Months	Days	Hours	Min.
during most of wo	ON (Give kind of work rking life, even if retired	dane 10b.	KIND OF BUSINESS OR IND			te or foreign	country)					COUNTRY
Milker			-		gland				U	nkne	MI	
13. FATHER'S NAME				14. MOTHE								
Unknown				U	nknow	n		100		47		
15. WAS DECEASED EV	ER IN U. S. ARMED FOR (If yes, give war ar dales of s	CES? 16.	SOCIAL SECURITY NO.	INFORMANT				Add	ress			
No	-	,	-	Springf	ield !	Hospit	al Re	cord	S 5			
18. CAUSE OF DE	ATH [Enter only one co	use per li	ine far (a), (b), and (c).]							INTE	RVAL B	ETWEEN
	ATH WAS CAUSED BY:									ONS		DEATH
592V	IMMEDIATE CAUSE (o		ronic nephriti	.5						+	Yea	48)
- 1ax	DUE TO)										
Canditians, if)(-		
gave rise to cause (a), stating	DIE TO)										
lying cause last)				1000						
PART II. OT	HER SIGNIFICANT CON	DITIONS	CONTRIBUTING TO DEATH BU	T NOT RELATED	TO THE TER	MINAL DISE	ASE COND	ITION GI	EN IN PAR	T 1(o) 1	9. WAS	AUTOPSY
Schison	hrenia, par	ranoi	d type.								YES T	DRMED?
20a. ACCIDENT W	AS UNDERLYING		CRIBE HOW INJURY OCCURR	ED. (Enter natur	of injury i	n Part I ar P	art II of it	em 18.)				,
	MEDICAL EXAMINER)										100	
20c. TIME OF INJU Haur a. m.	RY Month, Day, Ye			LACE OF INJUR			ity or tow	1)	(0	County)		(State
Haur a.m.	19	While at war	IAGL AUTIG	actory, siveer, ar	nce blog., e	.,						
21 1	h 1	deces	sed fram March 7	155	4- S	eptemb	er 7	1059) AL A. I. I		. 41	
alive an Ser	tombon 7	deceds	59 and that deat									
alive an Det	Demoet 1	, 19	59, and that deat	h accurred o	3.00.	1-11-57				e date		d abavı TE SIGNE
ACTUAL OF	- 7-	101	0.				(Street, cit			_	12 12	O SIGNE
SIGNATURE	quem a	rev	Churcho.	M.D. ST	ringi	ield S	tate	Hosp	ital	9/	1/5	9
PHYSICIAN'S NAME (Type)	Agustin	del Ca	mpo, M.D.	Sv	kesvi	lle, l	larvl.	and				
220. BURIAL CREMATIO			1 / .		and -		ATION		or country)		4.	ite)
REMOVAL (Specify		9	U. C. Ma.	Mel J	Choo	T	all	im	Pol.	M		
23. FUNERAL DIRECTO	R'S SIGNATURE	4	ADDRESS		24a. RE	CID BY REG	STRAR	24b. REG	STRAR'S S	GNATU	RE	
					DATE	11 PH	333	On	China	Peran	All.	



	A William	3.33	CERTIFIC	AIE OF DEATE	1		Reg. Dist. No	D.
. PLACE OF DEAT o. COUNTY	Carroll		MARYLAND	2. USUAL RESIDENCE (WHO O. STATE Mary)			n: Residence bel	
b. CITY OR TOV RURAL ond gi	/N (If outside corporate limits ve nearest town) minster	s, write c. LEN	of the of stay in 16	c. CITY OR TOWN (If o		limits, write RU		earest town)
d. NAME OF HO	OSPITAL (If not in hospital, given on Nursing E	ve street address)	d. STREET ADDRESS				IS RESIDENCE ON A FARM? YES NO [
B. NAME OF DECEASED (Type or print)	First WTT.T.TAN		Middle	Lost BARNES	4. DATE OF DEATH	Monit SEP		Day Year
s. sex	- • • •	7. MARRIED WIDOWED	NEVER MARRIED	8. DATE OF BIRTH 7-10-1875	9.	AGE (In years lost birthday)		R IF UNDER 24 H Hours Min
On USUAL OCCUP during most of Saw Mi				USTRY 11. BIRTHPLACE (Stole Mary)	or foreign count	7)	12. CITIZEN	OF WHAT COUN
3. FATHER'S NAMI	George W. E			Martha Bo				
15. WAS DECEASED (Yes, no. or unknown)	EVER IN U. S. ARMED FORC (It yes, give wor or dates of ser	rice) 16. SOCIAL		dgar R.Barne	es, Mai	rbury,		
couse (o), sto lying couse I	/ (6).	NITIONIC CONTRIL	BINTING TO DEATH BU	Thio The Layer To The Year		7		T
ICATI		final:		ED. (Enter nature of injury in F			N IN PART I(o)	PERFORMED?
ZOc. TIME OF IN	TIFY MEDICAL EXAMINER)	While _ N	OCCURRED 20e. P	PLACE OF INJURY (Home, farm actory, street, office bldg., etc.	, 20f. (City or	town)	(County	y) (Sto
21. I certify alive on	that attended the	deceased fro	, and that deat				nd on the d	saw the decedate stated abo
ACTUAL SIGNATURE	E Reese	Wi	1 Kens	mo. 15 Kenn 3 Mest	Ania Min	ster		md and
BURTA	ATION. 226. DATE THEREOF	59 Se		Brethren	Carro		,Md.	(Stote)
C. M.		Winfie	DDRESS Ld. Md.		EP 1 5 '59		Thun & K	

DATE SEP 1 5 '59

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may be retain by the haspital or attending physician.

TO FUNERAL I CLOR: After this certificate has been signed by the attending physician and campletely filled in the function of page 3 should be detached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, ar removal, and in any event within 72 hours after leath. TO HOSPITAL OR VS A15 (4) 1SM 9/SS

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. Page 4

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VS A15 (4) 1SM 9/SS M

ARYLAND	STATE	DEPARTMENT	OF HEALTH—BALTIMORE,	18

10100 CERTIFICATE OF DEATH

Reg. Dist. No. 10076

1. PLACE OF DEATH o. COUNTY Carroll MARYLANE	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Finksburg	c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town) XRural Finksburg
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	Route #1 Box 497 * Is residence on a farm? YES NO ON A FARM?
3. NAME OF DECEASED (Type or print) First Middle	BOHR 4. DATE Month Day Year OF DEATH SUPER 16 1959
S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED	
Male White WIDOWED DIVORCED	Octel7,1886 72 yrs. Months Days Hours Min.
10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	DUSTRY 11. BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT COUNTRY?
Retired B&O Farming	Quantico, Va. U.S.A.
IS. FAIRER 3 NAME	14. MOTHER 5 MAIDEN NAME
William Bohr Is. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17	Mary Groff
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes. no. or unknown) (If yes, give war or dates of service)	7. INFORMANT Address
No None 1705-12-3526	Mrs. Doris C. Bohr, Rt #1, Box 497
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)	- Mitastetie Interval Between ONSET AND DEATH
153,3 DUE TO	
Conditions, if any, which) (b) Oscaliones	- Deguide 3400.
gave rise to immediate code (a), stating the under-lying cause lost.	
, (4	BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) PERFORMED? YES NO ST
	RRED. (Enter nature of injury in Port I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED While Not while of work 19 of work 19	PLACE OF INJURY (Hame, farm, 20f. (City or town) (County) (State) factory, street, office bldg., etc.)
21. I certify that I attended the deceased from North	19.56, to Sept 16, 19.59, that I last saw the deceased
alive on Sept 15, 1959, and that dec	oth occurred at 1 M, from the causes and an the date stated above.
() 180. 1)	ADDRESS (Street, city or town, state) DATE SIGNED
SIGNATURE FALLES J. May SA	_M.D9/16/5
PHYSICIAN'S TAMES T. MARSH.	Mastumeter
220. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY REMOVAL (Specify)	
Burial ISeat 19,1950 Salem Me	thodist Cemeltery Winfield, Md.
Frank H. Deelsel- Tike	DATE SEP 2 2 '59 Carting & France

Carl Interes	TIPICATE OF DEATH.	161,	
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The state of the state of		1700	
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	Control Carlo III Control	TANK DESIGNATION	
	POLICE CONTRACTOR CONT		
-10.000			MIDT - NAME OF

HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If ony deloy is necessary, please	ar. Page	4 should be Marded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained from files.	f Heolth.	or its designated agent, prior to burial, cremation, or remaval, and in any event milhin 72 hours after death.
s necesso	o' deech	C	Boardo	
y deloy	he funer	e refoine	he Stote	er death.
th. If on	ind 3 to 1	5 may b	2 with 1	hours aft
ofter dea	ss 1, 2, o	3. Poge	es Lond	rithin 72
24 hours	Sive Pag	form PM	File pog	y events
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ertificate	J'pendi	edical Ex	be used	. crema
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PUTY M	tute the	ould be	INERAL I	ts design
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5M 2/57

10077 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

	5.05.05	Reg. Dist. No.
1.	PLACE OF DEATH D. COUNTY ARRALAND MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MAR LANDS. COUNTY CARPOLL
è	o. CITY OR TOWN (If outside corporate fimits, write RURAL on give nearest town)	c. City Or TOWN (If outside corporale limits, write RURAL and give nearest town)
	S. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	WESTMING / LEK NOT
	S. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give sifeet address) AT HOME	OLD BALTIMORE ROAD - VES NO
	NAME OF DECEASED (Type or print) WILLIAM First CHARLES 1	BOWSTEAD 4. DATE OF DOY YEAR SEPT. 23 1959
5, 5	6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. WIDOWED DIVORCED 3.	DATE OF BIRTH 9. AGE In years IF UNDER 14 ARS. Months Days Hours Min. Months Days Hours Min.
10a	USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRIBUTION most of working life, even if retired) POYLTRIR ZEIPP PHOTO, STUDIO.	11. BIRTHPLACE (State or fareign country) 12. CITIZEN OF WHAT COUNTRY? DENVER. COL. V.S.A.
13.	FATHER'S NAME	14. MOTHER'S MAIDEN NAME
	WILLIAM BOWSTEAD,	MARY ANN STICK
15. (Yes	no as unknown) I fif yes give was as dates of service)	FORMANT BE - Jans, WM. Clarks BOWSTEAD (HOME)
	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if ony, which gave rise to immediate cause (a), stating the underlying DUE TO	Throughosis interval Between ONSERIND DEAD ONSERIND DEAD SINCE OF THE PROPERTY ON THE PROPERTY OF THE PROPERTY
CERTIFICATION		OT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO PART 10 Port 1 or Port 11 of Item 18.)
CERT	PRIMARY or CONTRIBUTING CAUSE OF DEATH.	and the state of t
MEDICAL	20c, TIME OF INJURY Month, Doy, Year 20d, INJURY OCCURRED 40e. PLAC factor of work p. m. 19 of work of work 19	CE OF INJURY (Home, form, 201. (City or tawn) (Caunty) (State) pry, street, office bldg., etc.)
	21. I certify that I taak charge of the remains described above	ve, held an Autopsy 🔲, Inspection 💢, Inquiry 🔲, and in my
	apinion death resulted from: Natura causes XI, Accident [ACTUAL SIGNATURE PROBLEM ACCIDENT AC	M.D. CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER
	EXAMINER'S AAME (Type) acts	ELEPETY MEDICAL EXAMINER
200	REMOVAL (Specify) 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CONTROL OF LOUDEN P	CREMATORY 22d. LOCATION (City, lown, or county) (Stote) RK CEM BALTIMORE, MD
23.	FUNERAL DIRECTOR'S SIGNATURE LAMES 4. Callell - Westminster In	240. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DATE SEP 2 4 '59 Carihar J. Krank
1	Control of the contro	DATEGLE & TOO COLOMY & / CLAME

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	Asset and

		101	02	CERTIF	ICA	TE OF DEATH			Reg. Di	st. No.	[00]	78
	PLACE OF DEATH					2. USUAL RESIDENCE (Whe	re deceased	l lived. If institution	oni Resider	ice befo	re odmiss	ion)
o. COUNTY Carroll MARYLAND				AND	2. USUAL RESIDENCE (Where deceased lived. If institutions Residence before admission) o. STATE b. COUNTY Frederick						V	
	. CITY OR TOWN (IF	outside corporate limi	ts, write	c. LENGTH OF STAY	N 16	c. CITY OR TOWN (If ou		rate limits, write Rt		-)
	RURAL and give ne	arest town)	1	3 m 20 d		Mversv	1776		10	V	2	
	d. NAME OF HOSPITA	AL (If not in hospital, g				d. STREET ADDRESS	ofer sales sales (4)		-10		e. IS RES	
		ield State		ital								FARM?
3.	NAME OF DECEASED (Type or print)	Fir Add	ie	Harris		Browning	4. DATE OF DEATH	Septe	ember		, 1	Year 1959
5. 5	EX	6. COLOR OR RACE	7. MARR	IED NEVER MARRIE	D 0	. DATE OF BIRTH	1 1/2	9. AGE (In years				R 24 HRS.
	F.	White	WIDOW	DIVORCED		April 2, 187	1	last birthday) 88 yrs.	Months	Doys	Hours	Min.
	USUAL OCCUPATION during most of work	ing life, even if retired)		KIND OF BUSINESS OR OWN home	INDUS'	TRY 11. BIRTHPLACE (Stote o	-	h10	12. CI		F WHAT	COUNTRY
	FATHER'S NAME	readitor				14. MOTHER'S MAIDEN NA		71.70		001	7 4 45.0	
	unkno	um Ua	rris				n e en loren					
15	unkno			SOCIAL SECURITY NO.	17 IN	FORMANT	unkn	OWII -	P11		-100	
[Yes		If yes, give war or dates of si			1115		-4- 17			2		
		**		none	0	pringfield St	ate n	ospicar i	recor.			
	18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), ond (c).] PART I. DEATH WAS CAUSED 8Y: IMMEDIATE CAUSE (o) Terminal bronchopneumonia IMMEDIATE CAUSE (o)							DEATH				
	422.1	DUE TO										
	Conditions, if on		A:	rterioscler	otic	cardiovascul	lar di	sease		Years		
	gave rise to in couse (a), stating t	nmediate (-									
	lying cause lost.	le onder-	G	eneralized	arte	riosclerosis					Years	3
ATION	Chroni	c brain sv	ndron	e associate	TH BUT I	not related to the terminith cerebral	arter:	condition GIV	EN IN PAR	T 1(a) 1	PERFO	AUTOPSY RMED?
TIFIC	20g. ACCIDENT WA	SUNDERLYING			CURRED	. (Enter nature of injury in Po	ort I or Part	If of item 18.)			153	1404
CE	(IF EITHER, NOTIFY	CAUSE OF DEATH										
MEDICAL CERTIFICATION	Hour o. m.	/ Month, Doy, Yes	While	NJURY OCCURRED		CE OF INJURY (Home, form, ory, street, office bldg., etc.)	20f. (City	or town)	(County)		(Stote)
Z	p. m.					#0 0						
						, 1959 , to Se						
	alive on Se	Pta 17	112	22, and that of	death	accurred at 7:30A		the causes a		he da		ed above
	ACTUAL SIGNATURE	mstain	sh	Tuber		.b. Oak Stre						7-59
	PHYSICIAN'S K	onstantin	Weber	, M. D.		Sykesvil	le, M	aryland				
220	BURIAL, CREMATION	N, 226. DATE THEREO	F	22c. NAME OF CEMET	ERY OR	CREMATORY	22d. LOCAT	ION (City, tawn, a	or county)		(Stote	•)
	REMOVAL (Specify)	9-20-15	959	St. Par	ul'	s Lutheran	Mye:	rsville	. Fr	ed.	,	•
23.	FUNERAL BIRECTOR'S	SIGNATURE 121. H	B	ADDRESS	- 11	24a. REC'D		RAR 24b. REGIS		GNATUR	RE	

D FUNERAL CTOR: After this certificate has been signed by the attending physician and campletely filled in the funeral director, page 3 should readed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours offer death. Page 4 by the haspital ar attending physician. may be retain TO FUNERAL

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VS A15 (4) 15M 9/55

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CERTIFICATE OF DEATH

10079

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								Keg. Dist.	. 110.	
1. PLACE OF DEATH o. COUNTY Carr	011		MARYLANI	- 11	USUAL RESIDENCE (Wo. STATE Hary land	here decease	ed lived. If instituti b. COUNTY		before admission	on)
	f outside corporate limi	ls, write	c. LENGTH OF STAY IN 1	b /	c. CITY OR TOWN (IF	outside corp	orote limits, write l			
RURAL ond give no Rural. Wes			15 Yrs.		ural, Westm					
d. NAME OF HOSPIT	AL (If not in hospital, g	ive street		1	d. STREET ADDRESS	ALLES CC	*		e. IS RESI	DENCE
MODITIFICAL SO	r, Md. R.D.			W	estminster,	Md.R.	D.1 (Si17	ver Run	ONLA	FARM?
3. NAME OF DECEASED (Type or print)	Fir Mervin	st	Middle	Ca	lost Shman	4. DATE OF DEATH	Mar 1 9/25/			eor 9
5. SEX	6. COLOR OR RACE	7. MARR	IED WEVER MARRIED	8. D	ATE OF BIRTH		9. AGE (In years		YEAR IF UNDER	
Male	White	WIDOWE	DIVORCED	1	2/28/1878		lost birthday) 80 yrs.		ays Haurs	Min.
10a. USUAL OCCUPATIO	ON (Give kind of wark	ione 10b.	KIND OF BUSINESS OR IN	DUSTRY	11. BIRTHPLACE (State	ar foreign	cauntry)	12. CITIZ	EN OF WHAT	COUNTRY
Retired Car	ting life, even if refired		dg. all kinds		Pennsylvan			U.S	.A.	
13. FATHER'S NAME	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		e-24 carra territore		MOTHER'S MAIDEN					
Peter N.	Cashman				Laura My					
15. WAS DECEASEDEVE		CES? 16.	SOCIAL SECURITY NO. 117	. INFO		CAD	Add	Iress		
	(If yes, give wor or dates of t	rrvice)			Mervin E.	Casim			Md n	D 1
PART I. DEA	ATH [Enter anly one ca TH WAS CAUSED BY: IMMEDIATE CAUSE (a	0	ne far (a), (b), and (c);]	one	any Og	clus	ien		INTERVAL BET	WEEN DEATH
Conditions, if or gave rise to it cause (a), stoting	mmediate Dus To									1
lying cause last.) (c									
PART II. OTH	HER SIGNIFICANT CON	DITIONS C	ONTRIBUTING TO DEATH E	BUT NOT	RELATED TO THE TERM	NINAL DISEA	SE CONDITION GIV	VEN IN PART I	PERFOR	MED?
	S UNDERLYING CAUSE OF DEATH MEDICAL EXAMINER)	20b. DESC	CRIBE HOW INJURY OCCUP	RED. (E	nter nature of injury in	Part I ar Pa	rt II of item 18.)			
20c. TIME OF INJUR Hour a. st. p. m.	Y Month, Day, Yes	While	NJURY OCCURRED 20e. Not while at work	PLACE foctory,	OF INJURY (Hame, farr street, office bldg., etc	n, 20f. (Cit	ly or lown)	(Co	unty)	(State)
21. I certify the alive on	at I attended the	decease 12.5		ath oc	, 1957, to_ curred at 4.10)	M, fro	m the causes of Street, city on town.	and on the	date state	deceased d above TE SIGNED
PHYSICIAN'S NAME (Type)	LiL. P	OT	TER M.S),	12 W.K	ING	ST. LIT	TLES	TOWN:	PA
22a. BURIAL, CREMATIO REMOYAL (Specify)		F	22c. NAME OF CEMETERY	OR CR	MATORY	22d. LOC/	ATION (City, town,	or county)	(State)	
Burial	9/28/59		Church Of C	od (Cemetery	Unio	ntown, Ca	rroll :	Co., Md	4
23 FUNERAL DIRECTOR	SIGNATURE	17	ADDRESS			'D BY REGIS	TRAR 24b. REGI	STRAR'S SIGN	ATURE	2
A solicind	11.7/4	110 -			0	ED 2 R	'59 a	rement & :	Three	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 haurs after death: Page 4 VS A15 (4) 15M 9/55

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MARYLAND S	TATE	DEPARTMEN	NT OF H	EALTH-	BALTIMORE	, 18
1010 MEDICA	L EX	AMINER'S	CERTIF	FICATE (OF DEATH	1

10080

PLACE OF DEATH					2. USUAL RESIDEN			ed lived. If Institu	v _			
Carroll				LAND	Mary	rland	-		Pr		5 Ge	
b. CITY OR TOWN (If out and give nearest town)	side corporate limits, write RUR	IAL C.	LENGTH OF STAY	IN 1b	c. CITY OR TOY	YN (IF or	utside corp	orate limits, write	RURAL on	d give n	earest to	wn)
Sykesville			28 years		Muirki	irk	100	46	X - 0	ha		
d. NAME OF HOSPITAL Springfield			l, give street addre	35)	d. STREET ADDR	RESS					ON	A FARM?
		Luar			ll_none	TA						
3. NAME OF DECEASED (Type or print)	Constance	28	Middle H.	Co	ffin	4.	OF DEATH	9 Mont	h	27	1	959
S. SEX	. COLOR OR RACE 7.	MARRIED [NEVER MARRIE	D 1 8.	DATE OF BIRTH			9. AGE (In years	IFUNDER			ER 24 HRS
Male fema le	White W	DOWED [DIVORCED		6/18/77			79002 yrs.	Months	Bars	Hours	Min.
Oa. USUAL OCCUPATION during most of working lunknown	(Give kind of work done ite, even if retired)	10b. KIND	OF BUSINESS OR	INDUST	11. BIRTHPLACE				1	S.A		COUNTRY
13. FATHER'S NAME					14. MOTHER'S MAIL	DEN NA	ME					
Charles E.	Coffin				Oakkan	i na	D T	mac				
15. WAS DECEASED EYER		S? 16. SOC	IAL SECURITY NO.	17. B	Cather	THE	IL. U	Address		Uhrn	newo	od .
(Yes, no, or unknown) (If	yes, give war or dates of service	20)				7.61.	12 11	329 Wyngs				, ,
no	-		one		ohn C. Be	lfie	Id I,	ord Ange	100 10		Penn EVAL BETW	
	Enter only one cause p WAS CAUSED BY:	er line far ((o), (b), and (c).]							ONS	ET AND DE	ATH
IM	MEDIATE CAUSE (a)	Bron	chopneum	onia							Days	
1401.0	DUE TO											
Conditions, if any,		Acut	e perica	rdit	is					1	Days	1
gave rise to immediate (o), stating the una												
couse last.	(c)											
PART II. OTHER	SIGNIFICANT CONDITION	ONS CONTI	RIBUTING TO DEAT	H BUT N	OT RELATED TO THE	TERMINA	LDISEASE	CONDITION GI	VEN IN PAI	RT 1(a) 1	9. WAS	AUTOPSY PRMED?
Schizon	hrenic reac	tion.	henhreni	e tr	Pe left			trochant	eric		YES	NO
PART II. OTHER Schizop 200. EXTERNAL CAUSE PRIMARY D or CONTE CAUSE OF DEATH.	WAS 20h D				nter nature of injury i			of item 1B.)			Par!	
3 20c. TIME OF INJURY	Month, Day, Year	20d. INJU	RY OCCURRED 2	Oe. PLAC	E OF INJURY (Home	form,	20f. (City	ar town)	(Co	unty)		(State)
House Walle	9/16/ 19 59	While	Nat while at work	facto	ry, street, affice bldg			kesville		rro	17	Md.
	/ *				spital		CORD.					
1 7	t I taak charge of					topsy	[34, Ir	spection 🔀	, Inqui	ry 🖭	, and	find the
death resulted fr	rom: Natural cau	ises 1,	Accident	, Suid	ide, Homi	icide [, Ur	ndetermined	cause			
	0, 9	1.	1								DATE	SIGNED
SIGNATURE CLEE	ex //	ren			M.D. CHIEF MEDIC	CAL EXAM	MINER [DAIR	HUNED
//					ASSISTANT A	MEDICAL	EXAMINE	R 🔲			91	271
EXAMINER'S NAME (Type)	James T. Ma	arsh,	M.D.		DEPUTY MED	ICAL EX	AMINER T	9			1/	. /
22g. BURIAL CREMATION.	22b. DATE THEREOF	22c	NAME OF CEMET	ERY OR	CREMATORY	2	2d. LOCAT	TION (City, town,	or county)		(Stat	(e)
Burial Specify)	Oct 1, 195	59	St Johns	Cer	neterv			sville	Ma			
3. FUNERAL DIRECTOR'S			ADDRESS	001		REC'D	BY REGIST		STRAR'S SI	GNATU	RE	
F. Gasch	2					OCT	6 '5		Thun &			
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 - MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10081

Reg. Dist. No. 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) PLACE OF DEATH o. COUNTY b. COUNTY Carroll Carroll MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 rural-New Windsor rural -- New Windsor VIS. . IS RESIDENCE d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS ON A FARM? R.D. YES NO DATE OF DEATH NAME OF First Middle Lost Month Day Year DECEASED ROBERT S. COHEN SEPT. 22. 19 59 (Type or print) IF UNDER 24 HRS. 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 18. DATE OF BIRTH 9. AGE (In years IF UNDER TYEAR 49 Months Days Hours Min. white WIDOWED [DIVORCED T male 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT COUNTRY? U.S. Maryland Poul tryman owner 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Beatrice Rosenfeld S. Cohen Moses 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (If yes, give war or dates of service) Mrs. Elvira J. Cohen. Same 18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (0) DUE TO Conditions, if any, which gove rise to immediate cause **DUE TO** (o), stoting the underlying couse lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(3) 19. WAS AUTOPSY PERFORMED? NO V 20g. EXTERNAL CAUSE WAS PRIMARY Ø or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) Month, Day, Year 26d. NJURY OCCURRED 200. PLACE OF INJURY (Home, form, 20c. TIME OF INJURY 20f. (City or lown) (Stote) factory, street, office bldg. etc.) at work of work 21. I certify that I taok charge of the remains described above, held an Autopsy ... Inspection X and find that Suicide death resulted fram: Natural causes ... Accident . Undetermined cause Hamicide . DATE SIGNED CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER EXAMINÉR'S DEPUTY MEDICAL EXAMINER NAME (Type) 220. BURIAL, CREMATION, 226. DATE THEREOF 22c. NAME OF GEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (Stote) REMOVAL (Specify) Loudon Park Baltimore, Md. Cremation ADDRESS 23. FUNERAL DIRECTOR'S SIGNATURE 24g. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Winfield, Md. Waltz. DATECED 28

VS. A15ME(5) 5M 9/55

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

		- 1010	6	CERT	IFICA	TE OF DEATH	4		Reg. Dis		000	4	
1.	PLACE OF DEATH D. COUNTY Can	rroll		MAR	YLAND	2. USUAL RESIDENCE (Who o. STATE Marylar		b. COUNTY		e before		n)	
	b. CITY OR TOWN (If RURAL and give nea Sykesvil.	rest town)		LENGTH OF STATE		c. CITY OR TOWN (If o	utside corpo	orote limits, write R	URAL ond g	ive neare	st town)		
	d. NAME OF HOSPITA OR INSTITUTION Springfi	l (If not in hospitol, g				d. STREET ADDRESS 122 War	rren A	lve.			IS RESID ON A F		
3.	NAME OF DECEASED (Type or print)	Effi Effi	e May	Moon		ONNORS	4. DATE OF DEATH	Septem		Day 11,	Yes	~	
S.	Female	6. COLOR OR RACE White	7. MARRIED			May 20, 1872	2	9. AGE (In years lost birthdoy) 87 yrs.	Months		Hours	24 HRS. Min.	
	during most of working Laundress	ig life, even if retired	done 10b. KIN	ND OF BUSINESS	OR INDUST		Maryla		12. CITIZ		VHATCO	UNTRY?	
	Thomas O.					14. MOTHER'S MAIDEN N Ellen A.							
	WAS DECEASED EVER (If NO	IN U. S. ARMED FOR yes, give wor or dates of :		CIAL SECURITY N	NUR-	ringfield Hos	spital	L Records					
	PART I. DEAT	WAS CAUSED BY:) Acu	for (o), (b), and (c)	4	edema		in service		INTER ONSET	VAL BETV TAND D	WEEN DEATH	
	Conditions, if ony gove rise to im couse (o), stoting the lying couse lost.	mediate (Art	erioscle	rotic	heart diseas	se			Years			
CERTIFICATION		r significant con s with cer				OT RELATED TO THE TERMI	NAL DISEAS	SE CONDITION GIV	EN IN PART		PERFORA	NO T	
	20a. ACCIDENT WAS OR CONTRIBUTING [(IF EITHER, NOTIFY M	CAUSE OF DEATH	20b. DESCRI	BE HOW INJURY	OCCURRED.	(Enter noture of injury in I	Port I or Por	rt II of item 18.)					
MEDICAL	20c. TIME OF INJURY Hour o. m. p. m.	Month, Doy, Ye	20d. INJU While of work	Not while of work		CE OF INJURY (Home, form ory, street, office bldg., etc.		y or town)	(C	County)		(Stote)	
	actual SIGNATURE	tember 11,	1959 Mys	and that	t death	.b. Springfie	M, fram ADDRESS (S Id Sta	the causes an street, city ar town, ate Hospi	nd an the state)		tated o		
22	PHYSICIAN'S NAME (Type)	Frank N		M.D.		Sykesville							
1	REMOVAL (Specify)	9-15	59	USW	1.140	dischool	Ba	Con (City, town,	W	de	(Stote)		
23.	FUNERAL DIRECTOR'S	SIGNATURE		ADDIESS		240. REC'	BY REGIS		STRAR'S SIG				

CERTIFICATE OF DEATH

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10083

10107 CERTIFICATE OF DEATH

Reg. D	ist. No.	
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1, PI o.	ACE OF DEATH COUNTY CARROLL			MARYLAND	2. USUAL RESIDENCE a. STATE Marylan		d lived. If instituti b. COUNTY CITY	on: Residen	ce befo	re admissi	ion)
b.	CITY OR TOWN (I	f outside corporate limeorest town)	its, write	c. LENGTH OF STAY IN 16	c. CITY OR TOWN	(If outside carpo	orate limits, write R	URAL ond g	give nec	rest town)
	Sykesvill	le		2 days	Baltimore 3V01-4						
d.	NAME OF HOSPIT	AL (If not in haspital, g	give street	address)	d. STREET ADDRE	SS				e. IS RESI	IDENCE FARM?
	Springfie	eld State H	lospi	tal	3615 Ki	mble Ros	d				NO J
3. N	AME OF ECEASED	Fig	st	Middle	Last	4. DATE OF	Mar	nth	Da	у 1	Year
	ype or print)	Willia	m	Jay	Davis	DEATH	Sept	ember	3	3 1	1959
5. SE	Х	6. COLOR OR RACE	7. MARI	RIED NEVER MARRIED	8. DATE OF BIRTH		9. AGE (In years last birthday)	IF UNDER		-	
	Male	White	WIDOW	ED DIVORCED	February 1	2. 1882	77 yrs.	Manths	Doys	Hours	Min.
10a.	USUAL OCCUPATION		done 10b.	KIND OF BUSINESS OR INDU			country)	12. CITI	ZEN OF	WHATC	OUNTRY?
	Metal wor		<u>' </u>	4004	New Yo			U	S.A		
13. 1											
15 14	RRuben Da	R IN U. S. ARMED FOR	ceco la			Slocum					
		If yes, give war or dates of s	ervice)	2/22 22 22/2	INFORMANT		Add				
	No	tenta.			Springfield	Hospita	1 Record	8			
1			ouse per li	ne for (o), (b), and (c).]					INT	ET AND	DEATH
	PART I. DEA	TH WAS CAUSED BY: IMMEDIATE CAUSE (c	, 	Cardiac ins	ufficiency					ys	
	420.0	DUE TO									
	Conditions, if o		1	Myocardial	infarction				Ye	ars	
	gave rise to it cause (o), stoting	mmediate (,							-	
	lying cause last.) (c	:)(:	Arterioscle	rosis heart	disease		86.57	Ye	ars	
CATION	CBS due	to arterios	cler	CONTRIBUTING TO DEATH BU	T NOT RELATED TO THE I	TERMINAL DISEAS	E CONDITION GIV	EN IN PART		9. WAS A	AUTOPSY RMED?
CERTIFI	20a. ACCIDENT WA DR CONTRIBUTING IF EITHER, NOTIFY	S UNDERLYING CAUSE OF DEATH MEDICAL EXAMINER)	20b. DES	CRIBE HOW INJURY OCCURRI	ED. (Enter nature of injur	ry in Port I or Por	t II of item 1B.)				
MEDICAL	Oc. TIME OF INJUR Hour o. m. p. m.	Y Month, Doy, Ye	While		LACE OF INJURY (Hame, actory, street, affice bldg	farm, 20f. (City., etc.)	y ar tawn)	(0	County)		(State)
1	21. I certify th	at I attended the	deceas	ed from September	r 1, 19.59 to	Septembe	r 3. 19.59	that I la	st sav	v the di	eceased
				59, and that deat							
		1		10			treet, city or town,		duic		E SIGNED
1	ACTUAL COMMENTERS	quelu	del	Campo.	un Spring	rfield St	tate Hosp	Tette		2/3/4	50
	6	1			mio.	ya	ences-man	COLUMN		44-44-	
	HYSICIAN'S NAME (Type)	Agustin de	I Ca	mpo. M.D.	Sykesy	ille. M	aryland				
		N. 22b. DATE THEREC)F	22c. NAME OF CEMETERY C			TION (City, town,	or county)		(Stote	e)
	REMOVAL (Specify)	0/7/50		/ Parkwood	Com		Baltim	020 1	vd.		
23. FI	INERAL DIRECTOR	S SIGNATURE	- 1	ADDRESS //		REC'D BY REGIS		STRAR'S SIC		RE	
1/	VM1. 4.	Tiakones	LX	Mous - Da	(V) ()						
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FOR STATE HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please tecute the control case, writing the word "pending" in penal is them, 18. Give Pages 1, 2, and 3 to the funeral extern. Page should be to acred to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained four files. FUNERAL DIRECTOR: Page 3 should be used as a buriot-transit permit. File pages 1 and 2 with the State Board of Health, its designated agent, priar to burial, cremation, ar removal, and in any event, within 72 hours after death.

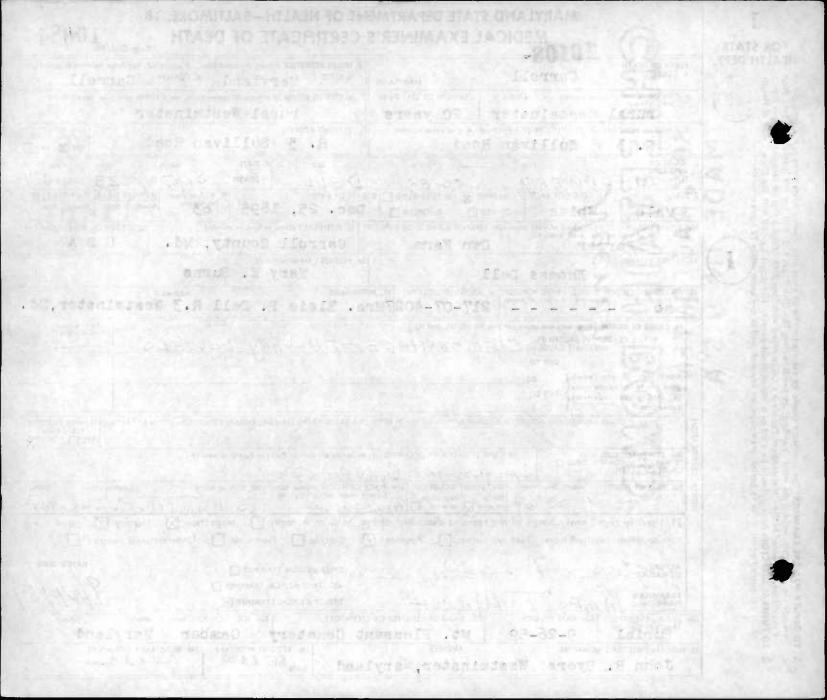
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 10084

	70109							
1. PLACE OF DEATH a. COUNTY	Carroll	MARYLAND	2. USUAL RESIDENCE (Where deceased on STATE Maryland	A COLUMNIA -	ce befare admission)			
b. CITY OR TOWN #1 and give negrest town PUPS.	9 997		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) rural Westminster					
d. NAME OF HOSPIT	Sulliva	t in hospital, give street address) N Road	7. STREET ADDRESS R. 3 Sulliv	an Road	e. IS RESIDENCE ON A FARM? YES NO			
3. NAME OF DECEASED (Type or print)	EDINARD	Middle NC& FR	DELL 4. DATE OF DEATH	Sept :	Doy Year 23 1959			
s. sex		MARRIED NEVER MARRIED DOWED DIVORCED	Dec. 25, 1895	AGE (In years of the control of the	YEAR IF UNDER 24 HRS.			
auring mast of working	ON (Give kind of work dane ng life, even if retired)	106. KIND OF BUSINESS OR INDUS OWN Farm	TRY 11. BIRTHPLACE (State or foreign count) Carroll County	140	EN OF WHAT COUNTRY			
13, FATHER'S NAME	Thomas D	ell	14. MOTHER'S MAIDEN NAME Mary E. Bu	ırns				
15. WAS DECEASED EV (Yes. no, or unknown)	(ER IN U. S. ARMED FORCES	16. SOCIAL SECURITY NO. 17. I 217-07-4027M		Address R.3 Westm	inster, Md.			
PART I. DEA	DUE TO iny, which (b) (b)	HEMORRHAGI	E-AXILLARY VE	SSELS	ONSET AND DEATH			
<u> </u>		ONS CONTRIBUTING TO DEATH BUT I	NOT RELATED TO THE TERMINAL DISEASE CO	ONDITION GIVEN IN PART	1(a) 19. WAS AUTOPSY PERFORMED? YES NO TO			
20g. EXTERNAL CAL PRIMARY OF COL CAUSE OF DEATH.	USE WAS NTRIBUTING [] 20b. D		Enter nature of injury in Part I or Port II of it RNPILICPR	tem 18.)				
20c. TIME OF INJUI	RY Manth, Doy, Year 9 23 159	20d. INJURY OCCURRED 20e. PLA While Not while	CE OF INJURY (Hame, farm, 20f. (City or or, street, affice bldg., etc.)		erree Mol			
opinion death	resulted from: Not	the remains described obcurol causes, , Accident	Suicide , Homicide	ection X . Inquiry], Undetermined ma	onner 🗌			
EXAMINER'S NAME (Typo)	AMES T	MARSH	M.D. CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER		9/24/5			
	9-26-59	22c. NAME OF CEMETERY OR Mt. Pleasa		(City, town, or county) Aber Mary	(State)			
23. FUNERAL DIRECTOR John R	the same of the same of the same of	ADDRESS stminster.Marv	24a. REC'D BY REGISTRAR		IATURE			



r death. Page 4

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CEPTIEICATE OF DEATH

10085

	TOTOR		CERTIFICA	AIL OF DEA	4111		Reg. Di	st. No.		
1. PLACE OF DEATH o. COUNTY Carroll	1		MARYLAND	2. USUAL RESIDENC o. STATE Maryla		ed lived. If instituti b. COUNTY		ice befo	re admiss	ion)
b. CITY OR TOWN RURAL ond give	(If outside corporate limits nearest town)	, write	c. LENGTH OF STAY IN 16			orote limits, write R	URAL ond	give nec	arest town	1)
RURAL ond give Sykesvil			47 years	Baltimo	re	3	VO1-	. 4-		
OR INSTITUTION	ITAL (If not in hospital, git Id State Hos			d. STREET ADDRE	squith S	St.				FARM?
NAME OF DECEASED	Firs		Middle	Last	4. DATE	Mor	ith	Da	ıy	Year
(Type or print)	Johr	1	K.	Fink	DEATI	н 9		26	,	1959
S. SEX	6. COLOR OR RACE	7. MARR	TED NEVER MARRIED	B. DATE OF BIRTH		9. AGE (In years	IF UNDER		-	T
ma Re	white	WIDOWE	DIVORCED	73unknown	3	737 yrs.	Months	Days	Hours	Min.
00. USUAL OCCUPAT	ION (Give kind of work d	ane 10b.	KIND OF BUSINESS OR INDU			cauntry)	12. CIT	IZEN OI	FWHATC	COUNTRY
	rking life, even if retired)		Tinh	Marvl	ond			U.S.	Δ	
Laborer 3. FATHER'S NAME			Monse	14. MOTHER'S MAII				0.0.	45. 0	
, TATTLE S TAME										
unknown				unkr						
5. WAS DECEASED EV (Yes, no, or unknown)	ER IN U. S. ARMED FORC		Social Security No. Sp.	ringileld H	lospital	Records	4"Ais	quit	h St	•
IB. CAUSE OF DE	ATH [Enter only one cou	se per lir		The second			No. VOI	T	ERVAL BE	TWEEN
	ATH WAS CAUSED BY:	A -	cute cardiac i	antfield	177			ONS	SET AND	DEATH
14 0	IMMEDIATE CAUSE (o)	AC	suce cardiac n	ismilicienc	<i>y</i>			1	dours	5
420.0	DUE TO									
Conditions, if	(0)	Co	ormary occlus:	ion				F	lours	5
gove rise to cause (a), stating										
lying couse last		.Aı	rterioscleroti	c heart dis	sease.)	lears	5
PART II. OT			contributing to death but			SE CONDITION GIV	EN IN PAR	(T 1(o) 1	PERFO	AUTOPSY DRMED?
OR CONTRIBUTION (IF EITHER, NOTIF	/AS UNDERLYING ☐ G ☐ CAUSE OF DEATH Y MEDICAL EXAMINER)	20b. DESC	CRIBE HOW INJURY OCCURRE	D. (Enter noture of inju	ory in Port I or Po	art II of item 1B.)				
20c. TIME OF INJU Hour a. m. p. m.	10	while	Not while fa	ACE OF INJURY (Home ctory, street, affice bldg		ty or town)	((County)		(Stote
21. I certify t	that I attended the	deceas	ed from March 7.	155 to	Sept. 2	6, 1959	that I le	ast say	w the d	ecense
	otember 26.			2:0	OPW	the			· · · · · · · · · · · · · · · · · · ·	d _L
dive di Dei	16678661 FA	_, 17	22, and mai deam	accurred di		Street, city or town,		e dare		TE SIGNE
ACTUAL /	as intai	10	O Charles	Con and an aud					0/2	7/50
SIGNATURE	gowin	uci	-winger.	W.D. Spring	riera 20	ate Hospi	.val		7/6	1/27
PHYSICIAN'S NAME (Type)	// Agustin d	elCar	mpo, M. W.	Sykesv	ille, Ma	ryland				
220. BURIAL, CREMATI REMOVAL (Specify	ON, 22b. DATE THEREON	59	22c. NAME OF CEMETERY O	R CREMATORY	22d. LOC	ATION (City, town,	or county)	-, -,	(Stat	te)
3. FUNERAL DIRECTO	R'S SIGNATURE	21	ADDRESS	1 / 240	. REC'D BY REGI	STRAR 24b, REGI	STRAR'S SI	GNATU	RE	-
Kultur N	4- Hough	46	Typewelle	ma, DAT	act 1	'59	Lithing	S. K	intel	

VS A15 (4) 15M 9/5B

Tage III . El pret TO MANAGEMENT ASSESSMENT TO THE PARTY OF THE warmin from oh mulendride ACCOUNT OF THE STATE OF THE SECOND OF THE SE September 25, 1964 State of the control of the cont The contract of the second state of the second state of the second secon DESCRIPTION OF CAME INC. All pestiles miner in the

FOR STATE HEALTH DEP TO DEPUTY DICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delegates a secund the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funers. Factor. Page 4 should be forwarded to the Chief Madical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARTIANIS & MEDICAL EXAMINER'S CERTIFICATE OF DEATH

			4044							
		PLACE OF DEAT	# 10110			2. USUAL RESIDEN	CE (Whera de			ca before edmission)
7			arroll		MARYLAND	. STATE Mary	hms [b. COUN	Carro	011
	b		if outside corporete limi	ts,	c. LENGTH OF STAY IN 16	c. CITY OR TOWN		orate limits, write	RURAL end give	neerest town)
		Write RUKAL and	d give neerast town)			X Tane	ytown			
,	d	. NAME OF HOSPI	TAL OR INSTITUTION (if not in ho	spitel, give street eddress)	d. STREET ADDRESS				. IS RESIDENCE
<			aneytown							YES X NO
		NAME OF DECEASED	First		Middle	Last	4. DATE	Month	Day	Year
	((Type or print)	HAR	RY	0.	FOGLE	DEATH	Septe	mber 29	1959
ř.	5.	SEX	6. COLOR OR RACE	7. MARRIE	NEVER MARRIED	8. DATE OF BIRTH	9.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
		Male	White	WIDOWI	D DIVORCED	April 3, 1898	32.91	61 yrs.	Months Deys	Hours Min.
	10a.	USUAL OCCUPAT	ION (Give kind of work	10b. K	IND OF BUSINESS OR INDUST		or foreign cou		12. CITIZEN C	F WHAT COUNTRY?
53	don	e during most of wo	orking lifa, even if retira		· Parm	Manualana				
u	13.	FATHER'S NAME		I OW	n farm	Maryland	NAME		Uei	S.A.
		0000								
5	16		nknown 'er in u.s. Armed for	CFF2 14	COCIAL CECURITY NO. 1.47	Margatet	Ann Fo			
			fyasgive war or dates of s		SOCIAL SECURITY NO. 17.	INFORMANT		Address		
	- 1	no			3-40-1352	Mrs. Harry F	ogle, I	aneyt o	wn, Md.	1
	-				ina for (a), (b), end (c).]					TERVAL BETWEEN
H		PART I. DEAT	H WAS CAUSED BY: IMMEDIATE CAUSE (a)	Gr	ushed skull					TOUR PERMIT
		9121	DUE TO							
		Conditions, if any	, which) (b)							
		geve rise to immed	iata cause							
		(a), steting the u	indariying						9.00 PG 13	
	7		P SIGNIFICANT CONDI	TIONS CON	TRIBUTING TO DEATH BUT N	OT RELATED TO THE TERMI	NAI DISEASE (CONDITION GIV	EN IN DART 1/-) 1	O WAS AUTORS
2	10	TAKI III OTTIC	K SIGINITE FINE			OT RESTREE TO THE TERM	THE DISCINCT			PERFORMED?
	5									YES X NO
	CERTIFICATION	PRIMARY OF CO	ONTRIBUTING [Ob. DESCR	IBE HOW INJURY OCCURED.	(Enter nature of injury in Pa	rt I or Pert II of	item 1B.)		
		CAUSE OF DEATH.				mulcher (mul				
	EDICAL	20c. TIME OF INJU	JRY Month, Day, Ye	or 2Dd. While		ACE OF INJURY (Home, ferr ctory, street, office bldg., atc		or town)	(County)	(Stete)
6	WED	bt.12 noo	n 9/29 19 E	4 - 1 -	Not Whila ta	Farm	į		Carro	11 Md.
	-				nains described above, h	eld an Autopsy X.	Inspection	, Inquir	y [], and	in my opinion
			from: Natural ca		-	cide , Homicide	□. Unc	determined m		, -,
		dodni josanog	14		Z t	CHIEF MEDICAL		1		
		ACTUAL	1 N 200		11 wing by			Contract of the Contract of th	MILES OF	
		SIGNATURE	V	_	10 / 19	M.D. ASSISTANT MED		K LA	0	ATE SIGNED
1		EXAMINER'S NAME (Type)	W. Bradl	enr Kil	ng, Jr., M.D.	DEPUTY MEDICA	L.		9/	30/59
OC.	22a.	BURIAL, CREMATIC	ON, 22b. DATE THERE	OF	22c. NAME OF CEMETERY C	Addrass (Street, DR CREMATORY		ON (City, town	or country)	(State)
		REMOVAL (Specify Burial	0ct. 1.	1050	Pooler U411 C	matam	Wood-	homo 16	San France	
	23.	FUNERAL DIRECTO		1777	Rocky Hill Co	emetery 24a, REC		boro, M.	STRAR'S SIGNATI	URE
		more	un trus						relun & the	
2		U.U.Fus	& Son	Ta	neytown, Mary	and DATE C	101 = 0			

A CENT TOWNSON T Dung Tonn CENTE LONG Sam ocalour 29 TO THE RESERVE OF THE PARTY OF April 3, 1808 stin-A Property Land Teg m To an Jone of 229-16-1572 Mee. Harry Togle, Conertoorn, Ma. SONE BEEF SILE • • Centre e att vollege . Il Surial - Ust. 3, 165 Stoner Hill Converses - - Hoodestry, Marriane alusia to fig. Tues a Son Comprison, Marriage

		1	U	(8	1
Reg.	Dist.					

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1. PLACE OF DEATH O. COUNTY Carroll MARYLAND					II.	o. STATE		here deceased yland	lived. If instituti b. COUNTY			re odmissi rick	ion)	
	b. CITY OR TOWN (RURAL ond give no Sykesvil		its, write		of STAY IN				outside corpor erick	ote limits, write R	URAL ond	give ne	, -)
	OR INSTITUTION	eld State I					d. STREET A		Record	Street				IDENCE FARM? NO
3.	NAME OF DECEASED (Type or print)	Mary	Corde	lia	Middle Davis		Fox	t	4. DATE OF DEATH	Septem		Do	,	Year 19 59
5.	SEX Female	6. COLOR OR RACE	7. MARRI	_	VER MARRIED DIVORCED [_	ATE OF BIRTH	_		9. AGE (In years lost birthdoy) yrs.	Months Months	R 1 YEAF Days	Hours	R 24 HRS. Min.
100	during most of wor	ON (Give kind of work king life, even if retired	done 10b. I	KIND OF E	BUSINESS OR I	NDUSTRY	1	ACE (Stote yland		untry)	12. CI	U.S		OUNTRY?
13.	FATHER'S NAME Franklin	Davis				1.	. MOTHER'S		Coblen	tz				
		R IN U. S. ARMED FOR (If yes, give war or dates of s		SOCIAL SE	CURITY NO.		rmant ringfi	eld H	ospita	1 Record	ress	20		
		ATH [Enter only one country was CAUSED BY: IMMEDIATE CAUSE (COUNTRY OF TO DUE TO	Art		b), ond (c).]	ic h	eart d	iseas	18				SET AND	DEATH
7	Conditions, if o gove rise to i couse (o), stoting lying couse lost.	the <u>under-</u>	:)		ized ar								Year	
CERTIFICATION	C.B.S.as Subc	SOC WITH CO SOC WITH CO ADITAL TRAC AS UNDERLYING []	cture	l ar neck	teriosc	hero	sis wi	th ps	ychoti	c reacti	On.	RT 1(o)	PERFO	NO T
MEDICAL CERT	20c. TIME OF INJUR Hour o. m.	CAUSE OF DEATH MEDICAL EXAMINER) Y Month, Doy, Ye	While	IJURY OCC	vhile		OF INJURY (I		n, 20f. (City	or town)		(County)		(Stote)
2	actual Signature	nat I attended the ptember 1, qualin' Agustin de	decease 19	ed fram	November and that de		Spr	6:45F ingfi	M, fram I	the causes ar reet, city or town, ate Hosp	nd an th		e stated	
220	BURIAL, CREMATIC	9-4-59	OF .		ormed					ION (City, town, Letown, 1			(Stote	e)
23.	FUNERAL DIRECTOR	s signature nison & Son	, Fre	deric	k, Mar	yland		24a. REC	D BY REGISTED 4 '59		STRAR'S S	1 .		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the deoth certificate be executed writing the library of the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, ar removal, and in any event within 72 hours after death. VS A15 (4) 1SM 9/SB

TOTAL SERVINGAGE OF DEATH

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TO HOSPITAL OR may be retain TO FUNERAL DI page 3 shauld of the registrar print

VS A15 (4) 15M 9/5B

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בובים בובים בובים בובים ביובים	After this certificate has been signed by the attending physician and campletely filled in by the funeral director.	hed far use as the burial-transit permit. Then please remave carban papers. Pages 1 and 2 shauld be filed with	rial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 10112

CERTIFICATE OF DEATH

Reg. Dist. No.

1.	o. COUNTY Carroll			MARYLAND		. STATE	aryl		l lived. If instituti b. COUNTY		roll		on)
	b. CITY OR TOWN (IF RURAL and give nea Sykesville	rest town)	its, write	6 vears	2%	city or to		itside corpoi	rate limits, write F	URAL and	give ne	arest town)
	d. NAME OF HOSPITA OR INSTITUTION Oringfield	L (If not in hospital, g		oddress)	-	Street ADD	PRESS	St.	10 V-100-W				DENCE FARM? NO
3.		Fir		Middle	-	Lost	001	4. DATE	Mor	aL.	Do		ear
	(Type or print)	ohn		William		Frush		OF DEATH	9	1111	5	,	959
5.				NEVER MARRIED		TE OF BIRTH			9. AGE (In years last birthdoy)	Months	R 1 YEAR	Hours	R 24 HRS. Min.
	male	white	WIDOWI		-	12/8/71			87 yrs.	10	26		
2	during most of working	N (Give kind of working life, even if retired to flour mi)	KIND OF BUSINESS OR INDU			ylan	d	ountry)	12.CI		S.A.	OUNTRY?
Г	William	Famolo				Mar	y Bo	70 Y					
15	. WAS DECEASED EVER	IN U. S. ARMED FOR	CES? 16.	SOCIAL SECURITY NO.	INFOR/		3 150	ger	Add	ress			
	'es, no, or unknown) (IF	yes, give war ar dates of s	ervice)			nk Frus	h	Homnai					
1	No CAUSE OF PEAT	u fr.	7-1	ne for (a), (b), and (c).]	rer	ik frus	Ш	uamba	tead, Md	•	LINIT	ERVAL BET	214/2514
				erioscleriosi:	a He	eart Di	Seas	A			ON	ears	
	1420.0					sclero							
	Conditions, if any)										
	gove rise to im cause (o), stating th												
	lying cause last.	(c	:)										
S	Chronico b			SARBRATING TO BEAT HIGH							RT 1(o) 1	9. WAS A	UTOPSY RMED?
ICA)	or nutrit:		e bra	in disease wi	th 1	psychot	ic r	eacti	on Enla	rged		YES 🗀	NO 🔯
CERTIFICATION		CAUSE OF DEATH	20b. DES	CRIBE HOW INJURY OCCURRE	D. (Ent	er noture of in	njury in P	art I or Port	II of item 18.)	Prost	ate		
MEDICAL	20c. TIME OF INJURY Hour a.m. p. m.	Month, Doy, Ye	or 20d. If While at wor	Not while fo	ACE O	F INJURY (Hostreet, office bl	me, form, ldg., etc.)	20f. (City	or town)		(County)		(Stote)
	21. I certify tha	t I attended the	deceas	ed fram. 8/ 9		, 19 59,	ta_9/	5	1959	that 1 l	ast sav	v the de	eceased
	alive an 9/5		, 19_	59_, and that death	acci	urred at4	30 A	M. fram					
	0		0.	0					reet, city or town,				SIGNED
	SIGNATURE SIGNATURE	ushin.	del	Caulps.	M.D.	Springf	ield	State	e Hospit	al	9	1/5/5	9
	PHYSICIAN'S A	gustin del	Camp	00 , M,D.		_Sykes	will	e Mai	ryland				
22	O. BURIAL, CREMATION REMOVAL (Specify)	9-8-	59	22c. NAME OF CEMETERY O	OR CRE				TION (City, Joyn,	or county	7	100	Ä
23	FUNERAL DIRECTOR'S	Signature	H	ADDRESS tead	n	12 D	4a. REC'D	BY REGIST		STRAR'S S			

Called Landing Co. Market & Co. . I'm at material approximation and the last section . intuined gradination to applicable the property and the state of the s any material and are and a later through a later and a through a later and any and a first and a second and a the state of the s CP/2/0 ... Louismolf educe Methanization Control 555 on Visit Language ALL COMPLETE MANUAL ANDRESS

T0112	CERTIFICATE OF DE	Reg. [Dist. No.
o. COUNTY Carriel Co	MARYLAND O. STATE	NCE (Where deceased lived. If institution: Reside	mil
RURAL and give recrest town. M. A	all he life X Russ	WN/Alf outside corporate limits, write RURAL once	give nearest town)
d. NAME OF HOSPITAL (If not in hospital, give street as OR INSTITUTION WATHERSTEE MARKET MAR	dress) d. STREET ADD d. STREET ADD	ege Atill	e. IS RESIDENCE ON A FARM? YES NO
R. NAME OF DECEASED (Type or print)	WILLIAR GEIMA	4. DATE Month OF DEATH SUB-t-	Day Year
Almale is lite WIDOWED	- VVWVV L	1894 Toys. Months	
Od. USUAL OCCUPATION (Give kind of work done 10b. Kind during most of working life, even if retired)	CA	mallo md.	HIS G
3. FATHER'S NAME MYSSIGMAN H. S.	elman 14. MOTHER'S M	AIDEN NAME	willian
5. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SC (Yes. no. or unknown) (If yes, give wor or dates of service)	OCIAL SECURITY NO. 17. INFORMANT	delame Hamas	Westminter
18. CAUSE OF DEATH [Enter only one couse per line PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)	for (o), (b), and (c).]	noushage.	INTERVAL BETWEEN OMSET AND DEATH
Conditions, if ony, which) (b)	andio Vaso	ularshielesa	Severit
gove rise to immediate case (a), stating the under- lying cause lost. Co	O-hesity		Heneral
PART II. OTHER SIGNIFICANT CONDITIONS CO	NTRIBUTING TO DEATH BUT NOT RELATED TO THE	HETERMINAL DISEASE CONDITION GIVEN IN PA	RT 1(0) 19. WAS AUTOPSY PERFORMED? YES NO
	IBE HOW INJURY OCCURRED. (Enter noture of i	njury in Port 1 or Port II of item 18.)	
20c. TIME OF INJURY Month, Doy, Year Hour o. m. While of work	Not while factory, street, office b	me, farm, 20f. (City or town)	(County) (State)
21. I certify that I attended the deceased	~	ta Sept 1, 1957, that	last saw the decease
ACTUAL SIGNATURE Wylens	Speisher W	ADDRESS (Street, city or town, store)	DATE SIGN
PHYSICIAN'S M. GLENNO	SPEICHER		
220. BURIAL, CREMATION, 226. BATE THEREOF REMOVAL (Specify) Subt. 1459	Medan Same	22d. LOCATION (City, town, or county)	
23. FUNERAL DIRECTOR'S SIGNATURE & MALER & MALER	The med	4a. REC'D BY REGISTRAR 24b. REGISTRAR'S S	S Krains

may be retained by the haspital or attending physician.

TO FUNERAL DI OR: After this certificate has been signed by the attending physician and campletely filled in by funeral director. page 3 shauld be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 25 should be filed with the registrar prior to burial, cremation, ar remaval, and in any event within 72 haurs after death. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

VS A15 (4) 15M 9/55

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	Salvania II		
and the same	Service State Control		
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MARYLAND STATE DEPARTMENT OF MEATHER BALLYRAM

TO HOSPITAL O

VS A15 (4) 15M 9/S8

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

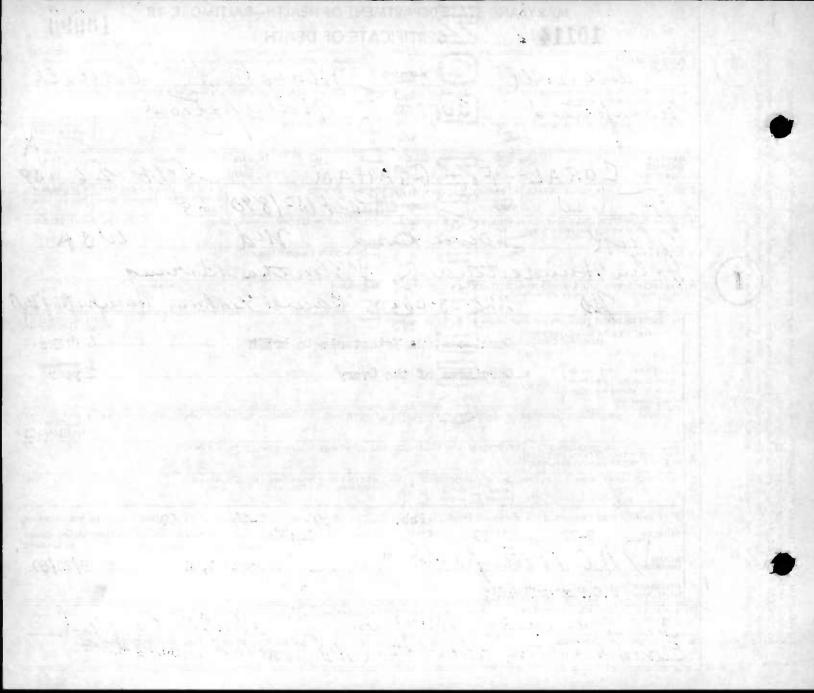
10114

CERTIFICATE OF DEATH

10090

Reg. Dist. No.

	PLACE OF DEATH D. COUNTY MARYLAND 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. SINTH (BULL) B. COUNTY COUNTY
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PURAL and give nearest town) According to the RURAL and give nearest town)
	d. NAME OF HOSPITAL (If nat in hospital, give street address) OR INSTITUTION e. IS RESIDENCE ON A FARM? YES \(\) NO
	NAME OF DECEASED (Type or print) CORAL- F - GRAHAM 4. DATE OF DEATH LOST 19 59
S.	SEX A 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH Oct 15 - 890 9. AGE (In years FUNDER 1 YEAR IF UNDER 24 HRS. Oct 15 - 890 9. AGE (In years FUNDER 1 YEAR FUNDER 24 HRS. Oct 15 - 890 9. AGE (In years FUNDER 1 YEAR FUNDER 24 HRS. Oct 15 - 890 9. AGE (In years FUNDER 1 YEAR FUNDER 24 HRS. Oct 15 - 890 9. AGE (In years FUNDER 1 YEAR FUNDER 24 HRS. Oct 15 - 890 9. AGE (In years FUNDER 1 YEAR FUNDER 24 HRS. Oct 15 - 890 9. AGE (In years FUNDER 1 YEAR FUNDER 24 HRS. Oct 15 - 890 9. AGE (In years FUNDER 1 YEAR FUNDER 24 HRS. Oct 15 - 890 9. AGE (In years FUNDER 1 YEAR FUNDER 24 HRS. Oct 15 - 890 9. AGE (In years FUNDER 1 YEAR FUNDER 24 HRS. Oct 15 - 890 9. AGE (In years FUNDER 1 YEAR FUNDER 24 HRS. Oct 15 - 890 9. AGE (In years FUNDER 1 YEAR FUNDER 24 HRS. Oct 15 - 890 9. AGE (In years FUNDER 1 YEAR FUNDER 24 HRS. Oct 15 - 890 9. AGE (In years FUNDER 1 YEAR FUNDER 24 HRS. Oct 15 - 890 9. AGE (In years FUNDER 1 YEAR FUNDER 24 HRS. Oct 15 - 890 9. AGE (In years FUNDER 1 YEAR FUNDER 24 HRS. Oct 15 - 890 9. AGE (In years FUNDER 1 YEAR FUNDER 24 HRS. Oct 15 - 890 9. AGE (In years FUNDER 1 YEAR FUNDER 24 HRS. Oct 15 - 890 9. AGE (In years FUNDER 1 YEAR FUNDER 24 HRS. Oct 15 - 890 9. AGE (In years FUNDER 1 YEAR FUNDER 24 HRS. Oct 15 - 890 9. AGE (In years FUNDER 1 YEAR FUNDER 24 HRS. Oct 15 - 890 9. AGE (In years FUNDER 1 YEAR FUNDER 1 YEAR FUNDER 24 HRS. Oct 15 - 890 9. AGE (In years FUNDER 1 YEAR FUNDER 24 HRS. Oct 15 - 890 9. AGE (In years FUNDER 1 YEAR F
L	a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? WATER'S NAME 14. MOTHER'S MAIDEN NAME
	Jahn Hundertinack Mentha Boring
	(WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. INFORMANT Address Ad
	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatous Motastasis to brain Weeks
	Conditions, if any, which gove rise to immediate cause (a), stating the under-lying cause last. (b) Carcinama of the Ovary DUE TO (c)
CERTIFICATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO
	20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II af item 18.)
MEDICAL	20c. TIME OF INJURY Month, Doy, Year Haur a. m. p. m. 19 20d. INJURY OCCURRED While at wark at work at wore work at
/	21. I certify that I ottended the deceosed from. Feb., 19.59, to 9.26, 19.59, that I lost saw the deceosed alive on 9.27, 19.59, and that death occurred otll:30 cM, from the causes and an the date stated above ADDRESS (Street, city or town, state) ACTUAL SIGNATURE M.D. Hampstead, Md 9/28/59 PHYSICIAN'S NAME (Type) M.C.P. rterfield
220	0. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (State) REMOVAL (Specify) 9-29-59 WW Jeon 2ulto Re Mild
23.	FUNERAL DIRECTOR'S SIGNATURE ADDRESS LEGISTRAR'S SIGNATURE DATE SEP 3 59 246. REGISTRAR'S SIGNATURE DATE SEP 3 59



VS A15 (4) 15M 10/57

DATE SEP 2 9 '59

24b. REGISTRAR'S SIGNATURE

10091

e. IS RESIDENCE

Hours

INTERVAL BETWEEN ONSET AND DEATH

> PERFORMED? YES NO

> > (Stote)

(Stote)

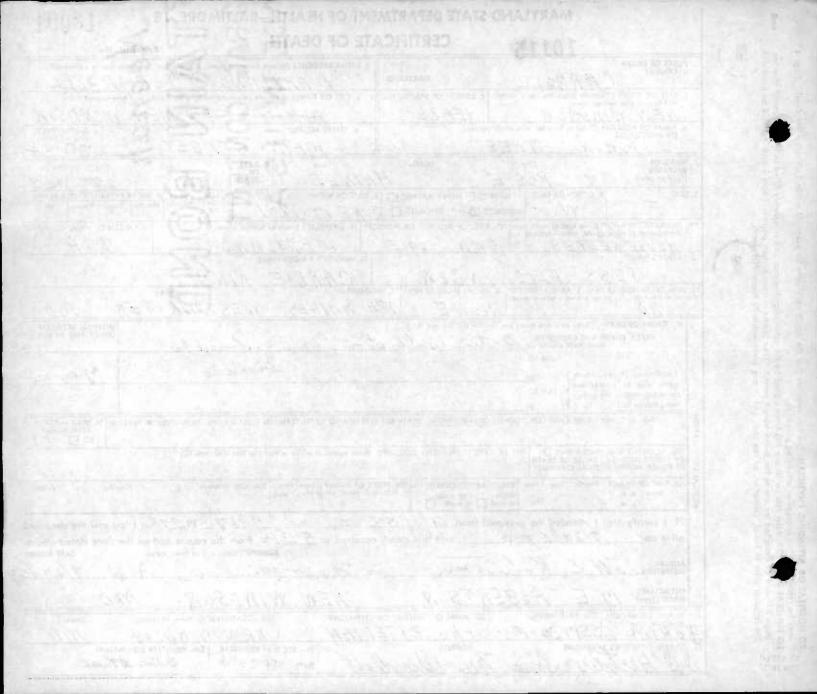
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(County)

ON A FARM? YES NO Z

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	Salar Salar			
	Francisco (C. S.)			

MARYLAND STATE DEPARTMENT OF HEALTH-RALTIMORE, 18

ADDRESS

24. REC'D BY REGISTRAR

246. REGISTRAR'S SIGNATURE

VS A15 (4) 15M 9/55

23. FUNERAL DIRECTOR'S SIGNATURE

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				中本作品 (2011年) 中本市
				有性不足器。

CERTIFICATE OF DEATH

MARYLAND

c. LENGTH OF STAY IN 16

10117

Carroll

RURAL and give nearest town)

b. CITY OR TOWN (If autside carporate limits, write

1. PLACE OF DEATH o. COUNTY

Reg. Dist. No.

Balto.City

2. USUAL RESIDENCE (Where deceosed lived. If institution: Residence before admission) b. COUNTY

c. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest tawn)

Maryland

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os	y b	S	Je.	rec		
I	ma	F	pag	the registror priar ta burial, cremation, or remayal, and in ony event within 72 hours after death.		
5 TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs often eath. Page 4		10	page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with	-		
VS	Al	5 (4)		6	·
15/	VA 9	1/5	5			Ç1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs often

VS

Sykesville		3mos.19da	ays Balt	imore 2	3	VO1-4	4
OR INSTITUTION	AL (If not in hospitol, give		d. STREET ADDRES	S			e. IS RESIDENCE ON A FARM?
	d State Hosp	ital	1102	Ashland	Court		YES NO
3. NAME OF DECEASED	First	Middle	Last	4. DATE	Month	De	ay Year
(Type ar print)	Willi			DEATH	Septem	nber 2	23. 1959
S. SEX	6. COLOR OR RACE 7.	MARRIED NEVER MARRIED				F UNDER 1 YEAR	
Male	White w	DOWED DIVORCED	May 13, 1	.886	73 yrs.	Manths Doys	Haurs Min.
10a. USUAL OCCUPATION	ON (Give kind of work dan	10b. KIND OF BUSINESS OR	INDUSTRY 11. BIRTHPLACE (S	tate ar foreign cou	intry)	12. CITIZEN O	F WHAT COUNTRY
Engineer	king tire, even ir renredj	Chemical Co	Maryl	and		U.S	-A-
3. FATHER'S NAME			14. MOTHER'S MAID		La Planta		
Lloyd Ho	uck		Mary	Baker			
S. WAS DECEASED EVE	R IN U. S. ARMED FORCES		INFORMANT	- 00	Addre	5\$	
No.	(If yes, give war or dates of service	212-05-8408	Springfield	Hospita'	Records		
IB. CAUSE OF DEA	ATH [Enter anly ane cause	per line far (a), (b), and (c).]			2. 1.0001 40	INT	TERVAL BETWEEN
	TH WAS CAUSED BY:						ISET AND DEATH
1777	DUE TO	Bronchopneum	outa				Days
Candidana		0	44	and delta manda		N N	fact ha
Canditions, if a gove rise to i	mmediate		the prostate	with met	astasis (50 M	lonths
couse (a), stating lying couse last.	the under-	liver and lu	ungs.			- 22	
	J (c)_	ONS CONTRIBUTING TO DEATH	H BUT NOT BELATED TO THE	EDMINIAL DICEACE	CONDITION CIVE	AL INI DADE NO.	19. WAS AUTOPSY
C.B.S.e	ssoc.with se	nile brain dise	ease with psyc	hotic re	action.	N IN PART I(0)	PERFORMED? YES NO
(IF EITHER, NOTIFY	AS UNDERLYING 206 CAUSE OF DEATH MEDICAL EXAMINER)	D. DESCRIBE HOW INJURY OCC	URRED. (Enter nature af injury	y in Part I ar Part	II of item 1B.)		
			De. PLACE OF INJURY (Hame, factory, street, affice bldg.		or town)	(Caunty)) (State
Haur a.m.		While Not while at work at wark	raciary, siteer, affice blag.,	eic.			
21. I certify th	at Lattended the de	eceased fram. June L	, 19.59, to_	September	£ 231059H	hat I last say	w the decease
		19 59 , and that d					
dive on		A O	edili accorred di tital		eet, city or town, st		DATE SIGNED
ACTUAL	laustin	del Cam	he Spring		ate Hospi		0/21/5
SIGNATURE	- Cherry	·		11010 00	10002	.001	21.531.2
PHYSICIAN'S NAME (Type)	4 — — — — — — — — — — — — — — — — — — —	delCampo, M	Sykesv	ille, Ma	ryland.		
22a. BURIAL, CREMATIO REMOVAL (Specify) Burial		New Cathed	ry or crematory		ON (City, tawn, ar	""	(State)
23. FUNERAL DIRECTOR	S SIGNATURE	ADDRESS	24a. 1	REC'D BY REGISTR		RAR'S SIGNATU	
George	2 Willes	1x a 63574	what Qu DATE	SEP 28 'S	59 a	Thus S. Kr	and
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ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 haurs after death. Page 4

TO HOSPITAL OR

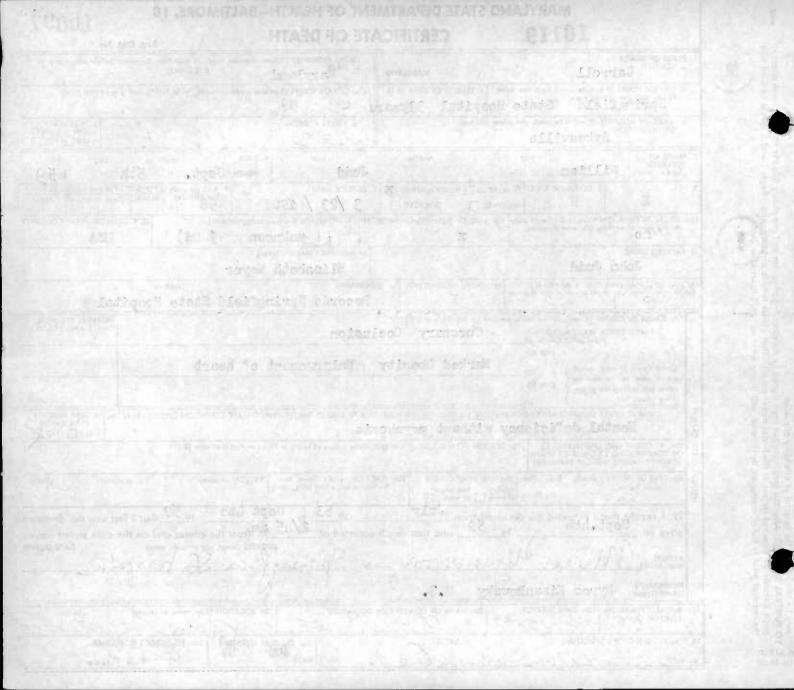
VS A15 (4) 1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10119

CERTIFICATE OF DEATH

10097 Rea. Dist. No.

1. PLACE OF DEATH o. COUNTY Car	roll	MARYLAND	II o STATE _	there deceased lived. If institution b. COUNTY	: Residence befor	e admission)
b. CITY OR TOWN (III	f outside corporate limits, write perest town) XState I	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (IF	outside corporate limits, write RUF	RAL and give near	rest fown)
OR INSTITUTION	AL (If not in hospitol, give stre Sykasville	et oddress)	d. STREET ADDRESS	eastle &	Ł	ON A FARM? YES NO
3. NAME OF DECEASED (Type or print) W:	First	Middle	Judd	4. DATE Month OF DEATH Sept.	5th	Yeor 1959
S. SEX	100	RRIED NEVER MARRIED MED DIVORCED	B. DATE OF BIRTH 3 /23 / 19	last birthdoy)	Months Days	IF UNDER 24 HRS. Hours Min.
0a. USUAL OCCUPATIO	ON (Give kind of work done ling life, even if retired)	b. KIND OF BUSINESS OR IND	1000	nown (Md)	12. CITIZEN OI	WHAT COUNTRY
3. FATHER'S NAME	Judd		14. MOTHER'S MAIDEN Elizabet			
5. WAS DECEASED EVE		6. SOCIAL SECURITY NO. 17.	INFORMANT	Address ingfield State F		
	the under (c) (c)	Marked Obesit s contributing to Death Bi without psych	UT NOT RELATED TO THE TERM	nt of heart	N IN PART 3(0) 15	P. WAS AUTOPSY PERFORMED? YES NO
20a. ACCIDENT WA OR CONTRIBUTING (IF EITHER, NOTIFY	S UNDERLYING 206. D	ESCRIBE HOW INJURY OCCUR		Port 1 or Part II of item 18.)		III NO AD
20c. TIME OF INJURY Hour e. m. p. m.	wh.		PLACE OF INJURY (Home, for factory, street, office bldg., etc.	m, 20f. (City or town)	(County)	(State)
ACTUAL SIGNATURE	ot I gitended the dece pt lith 19 My No A W.	our works	19		d on the dot	w the decease e stated obov DATE SIGNI
REMOVAL (Specify)	N, 226. DATE THEREOF	22c. NAME OF CEMETERY	or crematory	22d. LOCATION (City, town, or Warth Ave	county) Rat	(Stote)
23. FUNERAL DIRECTOR'S	S SIGNATURE	ADDRESS Of	240. PEG	HIND SU 46-U	RAPS MOPLATURE	



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I director,	Filed with	7 1
funera	should be	
illed in by	les I and 2	
e attending physicion and completely filled in by the funeral director	en please remove carban papers. Pages 1 and 2 should be filed to within 72 bours often death.	
cion and c	often dea	-
ding physic	en please remove carban nt within 72 hour oftende	
atten	en ple	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10120

CERTIFICATE OF DEATH

10098

			CATALOGUE TO SEE	Reg. Dist. No.
1. PLACE OF DEATH o. COUNTY Carroll	MARYLAND	2. USUAL RESIDENCE (Who	ere deceased lived. If institution b. COUNTY	Residence before admission) Baltimore
RURAL and give negrest tawn)	E. LENGTH OF STAY IN 16 Pyrs. 6mos. 2da		utside carporate limits, write RUF	RAL and give nearest town)
d. NAME OF HOSPITAL (If not in hospital, give street ad OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 29 Holms	shurst Ave.	e. IS RESIDENCE ON A FARM? YES NO
3. NAME OF First DECEASED (Type or print) Alden	Middle Brewer	Lawson	4. DATE Month OF DEATH Septembe	-
S. SEX 6. COLOR OR RACE 7. MARRIEI White WIDOWED		B. DATE OF BIRTH November 22,1	9. AGE (In years	F UNDER 1 YEAR IF UNDER 24 HRS. Manths Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	ND OF BUSINESS OR INDU			12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME	7 19 7 1	14. MOTHER'S MAIDEN N	AME	
Alden B. Lawson, Sr.		Bessie M	itchell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give wor or dates of service)		NFORMANT Springfield Ho	Address Ospital Records	
Canditions, if any, which gave rise to immediate cause (a), stating the under. DUE TO lying cause last. (c)	lateral brond			Days
PART II. OTHER SIGNIFICANT CONDITIONS CO Psychosis associated with 20d. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	organic chan	ges of nervous	s system, birth	19. WAS AUTOPSY PERFORMED? YES NO
	IBE HOW INJURY OCCURRE	D. (Enter nature of injury in P	art I ar Part of the 10.)	
Haur a.m. While at wark [Nat while for ot wark	ACE OF INJURY (Hame, farm, ctary, street, affice bldg., etc.		(Caunty) (State)
21. I certify that I attended the deceased alive an September 23, 19 5 ACTUAL SIGNATURE Agustin delCa	2 and that death Chings	M.D. Springfie		4 4
Burnel 9/26/59	22c. NAME OF CEMETERY O	ie	22d. LOCATION (City, town, or Button	o. md
23. FUNERAL DIRECTOR'S SIGNATURE	m 28	24a. REC'E		RAR'S SIGNATURE

TATE OF TADENS: 08101 a mention of the first terms of Montaline Production Street Street Assistant sturies in the second sturies of the second seco a main agreed to the same and a support a Ino the crit The second secon uthoosh Darfeshill Alaka than Appending of the section in state poster more relts where staying the reserve to ALTERNAL I SALES IN SMITH STORE THE TANK IN SALES Partners, of turners

I MEDICAL EXAMINER: Into certificate shaving be executed within 24 havrs after death. It any delay is necessary, please exe-	commente, writing the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral direct. Page 4 shauld be		AL DIRECTOR: Page 3 should be used as a burial-transit permit. File page. 1 and 2 with the registrar prior to burial, cremation.	
necessory.	. Page		ir to burial.	-
ny delay is	neral dire	your file:	gistrar pric	
leath. It ar	3 to the fu	stained far	with the re	
aurs after d	1, 2, and	5 may be re	seed and 2	
WITHIN Z4 N	Give Page	M3. Page 5	it. File pos	
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shauld be	in pencil i	ce alang w	s a burial-t	
S Certificate	"pending"	iner's Offi	be used as	
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VS. A15ME(5) 5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMOR	E, 18 10099
0127 Items 15 & 22 Film G249 10/5/59 iwk	Reg. Dist. No.

1		11127	tems 15	& 22 Fil	m G249 10/	5/59	iwk	Reg. Dis	t. No.
	PLACE OF DEATH				2. USUAL RESIDENCE	Where decea	sed lived. If Institu	tion: Residen	ce before admission)
	. O. COUNTY	Carroll		MARYLAND	O. STATE MOTO	yland	b. COUNT	Y Balt	co_City
		outside corporate limits, writ	e RURAL C.	LENGTH OF STAY IN 16			porote limits, write		
	Svkesvi		12	yrs.lmo.3da	ys Balt:	imore		3 Vo.	1-4.
	d. NAME OF HOSPIT	AL OR INSTITUTION	If not in hospitat,	give street address)	d. STREET ADDRESS				e. IS RESIDENCE
		ield State	Hospita	1	1033		aul St.		YES NO S
	3. NAME OF -DECEASED	Fir	ət	Middle	Last	4. DATE OF	Monti	h	Day Year
	(Type or print)		dridge	Stuart	Lee	DEATH	Septe	mber	10, 1959
	5. SEX	6. COLOR OR RACE	7. MARRIED	NEVER MARRIED			9. AGE (In years fast birthday)		YEAR IF UNDER 24 HRS.
	Male	White	WIDOWED	DIVORCED 🔲	December 7,		59 yrs.	Months D	ays Hours Min.
	loa. USUAL OCCUPATION during most of working	ON (Give kind of work g life, even if retired)	done 10b. KIND	OF BUSINESS OR INDU	STRY 11. BIRTHPLACE (Stote	or foreign	country)	12. CITIZI	EN OF WHAT COUNTRY?
	Electricia	n		-	Virginia	a		t	J.S.A.
	13. FATHER'S NAME			not we had	14. MOTHER'S MAIDEN	NAME		100	
	Henry S. L	ee			Virginia	a Rolp	h		
	15. WAS DECEASED EVI	ER IN U. S. ARMED FO	RCES? 16. SOCI	AL SECURITY NO. 17.	INFORMANT		Address		
	YAR NO/	- Cu lost Burn wer or come. or			Springfield	Hospi	tal Recor	ds	
ľ	18. CAUSE OF DEAT	TH [Enter only one can	use per line for (c), (b), ond (c).]					INTERVAL BETWEEN
		H WAS CAUSED BY	Amite	& chronic	myocardial in	nfarct.	ion	Day	onset and death
	420.1	DUE TO	ACGUS	a on the	MA OCAL GIAI II	il al Co	1011	Daj	o monons
	Conditions, if or		Conon	ary arterio	colonosis				Years
1	gave rise to immed	liote couse	00:00	ary ar octic	12 CTC1 02 12				16013
1	(o), stoting the couse lost.	inderlying fol							
1	PART II. OTH	IER SIGNIFICANT CON	DITIONS CONTRI	BUTING TO DEATH BUT	NOT RELATED TO THE TERM	UNAL DISEAS	E CONDITION GIV	EN IN PART 1	(a) 19. WAS AUTOPSY
	Psychosi	s with chr	onic alc	coholism wit	h deteriorat	ion.			PERFORMED? YES NO
	PART II. OTH Psychosi 200c. EXTERNAL CAU PRIMARY D or CON CAUSE OF DEATH.	ISE WAS TRIBUTING []	b. DESCRIBE HO	W INJURY OCCURRED.	Enter noture of injury in Por	rt I or Port II	of item 1B.)		
			r 20d. INJUR	Y OCCURRED 200. PL	ACE OF INJURY (Home, form	m, 20f. (City	or lown)	(Count	ly) (State)
	20c. TIME OF INJUR Hour o. m. p. m.	19	While of work	Not while for	tory, street, office bldg., etc	:-)	o. io mi	100011	(3,0,0)
		at I taak charge			ove, held an Autops	sy DC. I	nspection T	Inquiry	The and find that
					icide [], Homicide				Lar olla illa illa
1		1 6			, Hollineide	с <u>П</u> , о	ilderer illinied e		
	ACTUAL	Euca)	, 27	rarah	M.D. CHIEF MEDICAL E	XAMINER			DATE SIGNED
	EXAMINER'S NAME (Type)	James T.	Marsh,	M.D.	ASSISTANT MEDICAL				9/10/59
2	20. BURIAL, CREMATION REMOVAL (Specify)	N, 226. DATE THEREO	(EQ	ington Chu	crematory rhh Cemetery		TION (City, town, o		(Slote)
2	3. FUNERAL DIRECTOR	S SIGNATURE		ADDRESS		D BY REGIST		TRAR'S SIGN	
Ţ	Villiam Co	ok, Inc.,	1217 St	t.Paul Sre	eet DATE	SEP 15	'59 C	Cithun &	Krazza
Ber									

Service of the seatment the a Car of State and are no contributed from a first or relative manager dente out with a out that the same of the A STATE OF THE PROPERTY OF THE PARTY OF THE en la sala de la sala meto de la compa ÷ % & A STATE OF THE PARTY OF THE PAR defeater to be seen Strong Latings Lie Tember? and a full open in 1975 and the collection of the State o control of the contro SHOULD SELECT TO MADE SET OF MENTS OF ISSUED FROM SECURIOR SERVICES FOR A PROPERTY OF THE PROP and continuous of the section of the The state of the s The second state of the second The state of the s MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10122 CERTIFICATE OF DEATH

Reg. Dist. No PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. COUNTY Carroll o. STATE Maryland b. COUNTY Baltimore City MARYLAND b. CITY OR TOWN (If outside carporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) Sykesville Baltimore hlyrsllmth.27dvs. d. NAME OF HOSPITAL (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE Springfield State Hospital. ON A FARM? 1629 Kingsway Road. YES NO C.Lippert 4. DATE 1959 DECEASED Thomas DEATH (Type or print) 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 15 B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthdoy) Months Days Haurs Male White WIDOWED | DIVORCED | yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stote or fareign country) 12. CITIZEN OF WHAT COUNTRY? U.S.A. Maryland Clerk 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME John G. Lippert Agnes Kellen 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO INFORMANT Address Hospital records no 1B. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Intestimal obstruction due to volvulus. IMMEDIATE CAUSE (o) days DUE TO Conditions, if ony, which Broncho-pneumonia hours gave rise to immediate DUE TO couse (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(d) 19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I ar Part II of item 1B.) 20c. TIME OF INJURY 20e. PLACE OF INJURY (Home, form, Doy, Year 20d. INJURY OCCURRED 20f. (City or town) (County) (Stote) foctory, street, office bldg., etc.) o. m. Not while of work of work 159, that I last saw the deceased 21. I certify that I affended the deceased fram 3-7alive an 9-26 and that death occurred a COLA M, from the causes and an the date stated above. DATE SIGNED ADDRESS (Street, city or lown, stote) Springfield State Hospital. Sykesville, Maryland. Agustin del Campo M.D.

NAME (Type) 220. BURIAL, CREMATION, 22b. DATE THEREOF REMOVAL (Specify)

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, tawn, or county) Balto.

(Stote)

23. FUNERAL DIRECTOR'S SIGNATURE

Burial

Loudon ADDRESS

24d. REC'D BY REGISTRAR SEP 2 8 59 DATE

24b. REGISTRAR'S SIGNATURE

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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	70724		CEKTIFIC	AI	E OF DEATH			Reg. Di	st. No.		
1. PLACE OF DEATH o. COUNTY	Carroll		MARYLAND		USUAL RESIDENCE (Who o. STATE Maryl		lived. If instituti b. COUNTY				sion)
b. CITY OR TOWN RURAL and give Syke sy		, write c	LLyrs 6mos		c. CITY OR TOWN (IF of Baltim		ote limits, write R	URAL ond	give nec	arest town	n)
d. NAME OF HOS	SPITAL (If not in hospital, gi-		dress)		d. STREET ADDRESS 6115 S	tanton	Ave.				SIDENCE FARM?
3. NAME OF DECEASED (Type or print)	First Johr		Joseph	Mo	Lost CNamara	4. DATE OF DEATH	Septe	mber	Do	۱,	Year 19 59
s. sex		7. MARRIEI	D NEVER MARRIED L DIVORCED		September 6,	1878	AGE (In years lost birthdoy) yrs.	IF UNDER Months	1 YEAR Days	Hours	ER 24 HR Min.
during most of v	ATION (Give kind of work devorking life, even if retired) rearrier	one 10b. KI	ND OF BUSINESS OR IND	DUSTRY	11. BIRTHPLACE (Stote of Maryland		untry)		S.A	WHAT	COUNTR
13. FATHER'S NAME John M	cNamara			1.	4. MOTHER'S MAIDEN N		•				
15. WAS DECEASED I (Yes, no, or unknown)	EVER IN U. S. ARMED FORC		OCIAL SECURITY NO.		RMANT ringfield Ho	spital	Record				
	DEATH [Enter only one cou DEATH WAS CAUSED BY: A IMMEDIATE CAUSE (6)			lear	t disease				ONS	ERVAL BE	
Conditions, if gove rise to couse (o), stotillying couse to	ng the <u>under-</u>	enera	lized arteri	Losc	lerosis				уе	RRS	
Part II. (other significant cond	itions col	NTRIBUTING TO DEATH B	UT NO 0518	T RELATED TO THE TERMI	NAL DISEASE	condition given the condition of the con	ting.	T 1(o) 1	9. WAS PERFO YES	AUTOPS DRMED?
OR CONTRIBUTION	WAS UNDERLYING ☐ 2 NG ☐ CAUSE OF DEATH IFY MEDICAL EXAMINER)	ЮЬ. DESCR	IBE HOW INJURY OCCUR	RED. (E	inter noture of injury in F	ort I or Port	tl of item 1B.)				
20c. TIME OF IN.	m,	While	URY OCCURRED 20e. Not while of work	PLACE foctory	OF INJURY (Home, form, street, office bldg., etc.	20f. (City	or town)	(1	County)		(Stol
actual signature	that I attended the ptember 14,	, 12 59	Compo		. 1955, to Se courred at6:00P Springf: Sykesvil	M, from t ADDRESS (Str. Leld He	he causes an eet, city or town, ospital	d an the	e date		
220. BURIAL, CREMA REMOVAL (Spec	TION, 22b. DATE THEREOF	-	22c, NAME OF CEMETERY	OR CR			ON (City, town,	or county))	(Sto	te)
23. FUNERAL DIRECT	OR'S SIGNATURE	1/ Se	ADDRESS W	nut		EP 1 8		STRAR'S SI			

TO FUNERAL DIRECT
page 3 should be a
the registror prior t TO HOSPITAL VS A1S (4) 1SM 9/S8

death. Page 4

be filed with uneral director

attending physician and completely filled in by me fun

offer de

72 hours

Then please

After this certificate has been signed by the use as the burial-transit permit.

remayal,

haspital or attending physician.

TENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs

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(1-2) - 3s	10179	B	CERTIF	ICA	IE OF DE	AIF			Reg. I	Dist. No.		
. PLACE OF DEATH o. COUNTY	rroll		MARYLA		2. USUAL RESIDEN o. STATE Ma	ce (Who		l lived. If instituti b. COUNTY		ence befo		ion)
b. CITY OR TOWN RURAL ond give Sykesvill	(If outside corporate limit nearest town)		LENGTH OF STAY IN				utside corpor more	rote limits, write R	3 V	give ned	arest town	1)
d. NAME OF HOSP OR INSTITUTION	ITAL (If not in hospital, gi	ve street oddr			d. STREET ADDI		West S	Street				FARM?
NAME OF DECEASED (Type or print)	Firs Marga		Middle		Miller		4. DATE OF DEATH	Septen		3,	у	Yes 9
Female Female	6. COLOR OR RACE White	7. MARRIED		8.	DATE OF BIRTH February	23,	1893	9. AGE (In years lost burthdoy) 66 yrs.	Months Months	-	Hours	ER 24 HRS. Min.
during most of wo None	ION (Give kind of work d orking life, even if retired)	one 10b, KIN	D OF BUSINESS OR	INDUST	Maryla		or foreign co	ountry)	12.C	U.S		OUNTRY
Joseph M	iller				Mary							
S. WAS DECEASED EV Yes, no. or unknown)	(ER IN U. S. ARMED FORC		IAL SECURITY NO.		ormant ingfield	Hos	pital	Records	ress			
1100	EATH [Enter only one country o	0	r (o), (b), ond (c).]	nkno	wn origi	n wi	th met	tastasis		INT ON:	ERVAL 88 SET AND	DEATH
Conditions, if gove rise to couse (a), stating lying couse lost PART II. O Sociopa 20a. ACCIDENT WOOR CONTRIBUTING (IF EITHER, NOTIF	immediate DUE TO	ilions con	TRIBUJING IO DEAT	TH BUT N	ot related to the	ETERMII	NAL DISEASE actio	CONDITION GIV	/EN IN PA	ART 1(o) 1	9. WAS PERFO	AUTOPSY DRMED?
	VAS UNDERLYING DEATH OF CAUSE OF DEATH OF MEDICAL EXAMINER)	20b. DESCRIB	E HOW INJURY OC	CURRED.	(Enter noture of in	jury in P	ort I or Port	II of item 18.)				
20c. TIME OF INJU	10	While of work	Not while	Oe. PLAC	E OF INJURY (Homory, street, office bloom	ne, form, dg., etc.	20f. (City	or town)		(County)		(Stote)
alive on _Se ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)	Francesco 9N, 22b. DAJE THEREO	19.59 Magro,	and that of	death o	occurred at 8 D. Spr	:10F	M, from ADDRESS (SI		nd on t stote) spit	he date	stated	d abave re signed /59
REMOVAL (Specification) 3. FUNERAL DIRECTO	7/3/3	-9 1	New Cet	hea	rul Cen	-	DAY REGIST	Bellem	STILLARS	MC SIGNATU	A. 1964	
Games	Burnaid	- 4	- 955 L	w the	IN ON	ATE S			Inthun			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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		1012	26	CER	TIFIC	ATE OF DEA	ATH		Reg. D	ist. No		
1.	PLACE OF DEATH o. COUNTY C	arroll		MA	RYLAND	o. STATE	E (Where deced	sed lived. If instituti b. COUNTY		nce befo	re admis	sion)
	b. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 2mos.18days:				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 1 3 V 0 / - 44							
	OR INSTITUTION	AL (If not in hospital, gleated State		address)		d. STREET ADDR		rette St.				SIDENCE A FARM? NO
3.	NAME OF DECEASED (Type or print)	Fi		Midd		Nerking	4. DATE OF DEAT	Mor		2	,	Yeor 19 59
S.	Male	6. COLOR OR RACE White	7. MARR	IED NEVER MAR	RRIED 🛣	B. DATE OF BIRTH April 17,	1891	9. AGE (In years lost birthday) 60 yrs.	Months	Days	Hours Hours	ER 24 HRS. Min.
	Metal W	ing life, even if retired	dane 10b.	KIND OF BUSINESS	OR IND	ustry 11. Birthplace Maryli		country)	12.CIT	U.S		COUNTRY?
	FATHER'S NAME Unknown					14. MOTHER'S MAI						
15. (Ye		R IN U. S. ARMED FOR (If yes, give war or dates of s	ervice)	12-14-200		Springfie	ld Hospi	Ltal Recor				
		TH [Enter only one co TH WAS CAUSED BY: IMMEDIATE CAUSE (c)1	me for (a), (b), and (Metastati		rcinoma	124			ONS	ERVAL BE SET AND Week	DEATH
	Conditions, if an gove rise to in cause (o), stating lying cause last.	mmediate ()	Cancer of	the	rectum					Mont	hs
CATION		ier significant con Brain Syndi		CONTRIBUTING TO I	DEATH BU	T NOT RELATED TO THE	TERMINAL DISEA	ASE CONDITION GIV	EN IN PAI	RT 1(o) 1	PERFC	AUTOPSY ORMED?
CERTIFI	20a. ACCIDENT WA OR CONTRIBUTING (IF EITHER, NOTIFY	S UNDERLYING CAUSE OF DEATH MEDICAL EXAMINER)	20b. DESC	CRIBE HOW INJURY	OCCURR	ED. (Enter noture of inju	ury in Port I or P	ort II of item 1B.)				
MEDICAL	20c. TIME OF INJUR Haur a. m. p. m.	Y Month, Doy, Ye	While	Not while at work	20e. P	LACE OF INJURY (Hame actory, street, office bld	e, farm, 20f. (C g., etc.)	ity ar tawn)	(County)		(State)
		tember 23,	19 d		at deat	M.D	OOAM, from ADDRESS field S		d an th		stated	
7	BURIAL, CREMATIO REMOVAL (Specify)	9-28-	59	22c. NAME OF CE	METERY (minicital Fa	22d. LOC	ATION (City, town,	or county) STRAR'S SI	CL46	(Sto	wy.
1	tellets) 3	H. Haig	19 (Hykeon	relle	, 9/4. DA	CCT	1 59	Lilling.	2 14	inthis.	

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ely filled in by me Tuneral directar, Pages 1 and 2 should be filed with

death. Page

CERTIFICATE OF DEATH

	70744	OEK III IO	TIE OI DEATI	•		Reg. Dist.	No.	
1. PLACE OF DEATH			2. USUAL RESIDENCE (WHO O. STATE	ere decease			before admi	ssion)
	arroll	MARYLAND	Maryla	and	b. COUNTY	Balto	.City	/
RURAL and give n	If autside carparote limits, write earest town)		c. CITY OR TOWN (If o	utside corpo	orate limits, write R	URAL ond giv	e nearest to	vn)
Sykesvi		iyr.4mos.15da		nore	3 v	01-4		
OR INSTITUTION	TAL (If not in hospital, give stre		d. STREET ADDRESS					A FARM?
	field State Ho	spital	1517 8	_	ton St.		YES [] NO [
NAME OF DECEASED	First	Middle	Lost	4. DATE OF	Mon		Day	Year
(Type or print)	Martin	Francis	Nevins	DEATH	Septer		24,	1959
SEX			B. DATE OF BIRTH	,	9. AGE (In years lost birthday)	Months De	YEAR IF UNI	
Male		WED DIVORCED	June 10, 190		53 yrs.			
during most af wor	ON (Give kind of work dane 10 king life, even if retired)	Db. KIND OF BUSINESS OR INDUS			ountry)		N OF WHAT	COUNTRY
Unknown L FATHER'S NAME		une.	New Je			U.	S.A.	
			14. MOTHER'S MAIDEN N					
Martin No	ER IN U. S. ARMED FORCES?	14 SOCIAL SECURITY NO "	Lettia NFORMANT	Judge	Add			
Yes, no, or unknown)	(If yes, give war or dates of service)				3 11 11			
No	•		Springfield Ho	ospita	1 record	3		
	ATH [Enter only one cause per	line for (o), (b), ond (c).]					ONSET AN	D DEATH
PART I. DEA	IMMEDIATE CAUSE (0)	oronary occlusio	on				Minut	es
002X	DUE TO	(38 S./113 A.						
Conditions, if a	ny, which) (b) F.	ar advanced bula	nonary tubercu	losis			Years	
gove rise to i								
lying couse lost.) (c)							
PART II. OTI	HER SIGNIFICANT CONDITION	IS CONTRIBUTING TO DEATH BUT	NOT RELATED TO THE TERMI	NAL DISEAS	E CONDITION GIV	EN IN PART 1	(a) 19. WAS	ORMED?
Schlzoph	renic reaction	, paranoid type.] NO
OR CONTRIBUTING	AS UNDERLYING 20b. D CAUSE OF DEATH MEDICAL EXAMINER)	ESCRIBE HOW INJURY OCCURRED	D. (Enter noture of injury in I	Part I ar Por	t II af item 1B.)	-		
20c. TIME OF INJUI Hour o. m. p. m.	Y Month, Day, Year 20d	. INJURY OCCURRED 20e. PL	ACE OF INJURY (Hame, farm	, 20f. (City	or town)	(Cou	inty)	(Stat
Hour o.m.	19 Wh	ile idol willie	ctory, street, office bldg., etc.	.)				
			1958 to Ser	towho	7 2150			
21. I certify if	tember 24, 19				T 24,1959	that I last	saw the	decease
alive an Deb	cember 24, 19	59, and that death	accurred at 5:151		the causes an treet, city or town,			ed abay
ACTUAL (7)	auntin de	O Ban bo					0/0	2 /20
SIGNATURE	feceron cex	ce conseque	M.D. Springfiel	ra sta	re nospi	raT	9/2	2/27
PHYSICIAN'S NAME (Type)	Agustin delCa	mpo, M.D.	Sykesville	e, Mar	yland			
20. BURIAL, CREMATIC		22c. NAME OF CEMETERY OF	R CREMATORY	22d. LOCA	TION (City, town,	or county)	(Ste	ote)
REMOVAL (Specify)	9-29-59	St Joseph	(0)	ale	utston	0, 4	100-4	ork
B. FUNERAL DIRECTOR	S SIGNATURE	ADDRESS DA	240. REC'I	D BY REGIST		STRAR'S SIGN	ATURE /	
Julker.	H-Halglif	Co. yhuevelle	DATE DATE	CI 1	59 0	rihun &	Tunka	

may be retain the haspital or attending physician.

2 FUNERAL DAY, CTOR: After this certificate has been signed by the attending physicion and completely filled in by page 3 shauld be detached far use as the burial-transit permit. Then please remave carbon papers. Pages 1 and 2 the registrar prior to burial, cremation, ar remaval, and in ony event within 72 hours ofter death. TTENDING PHYSICIAN: The law requires that the deoth certificate be executed within 24 haurs TO HOSPITAL OF may be retain TO FUNERAL DE VS A15 (4) 15M 9/5B

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DATE

CERTIFICATE ÖF DEATH 10128

Reg.	Dist.	No

1. PLACE OF DEATH		2. USUAL RESID	ENCE (HOME) OF DECE	ASED
COUNTY Carroll	MARYLAND	STATE PE	nna. county 1	Vortheumberha
CITY (If outside corporate limits, write RURAL	I LENGTH OF STAY	OI/AIL -	rporate limits, write RURAL end giv	
OR and give nearest town)	(in this plece)	OR '	rural Sunbury	(11- 0
Large Laurenare	I Month		Fural Sumbury	10 X=3
HOSPITAL OR INSTITUTION OR PROME PORT		STREET ADDRESS	(If rural give loca	tion)
STREET ADDRESS home -Mrs. N. He	erman			
DECEASED	(Middla)	(Last)	4. DATE (Month)	(Dey) (Yeer)
(Type or Print) Agnes Verd1:	lla News	ian	DEATH SEPT	. 29 1959
S. SEX 6. COLOR OR 7. SINGLE, MARRI		F BIRTH	9. AGE last birthdey IF U	INDER 1 YEAR IF UNDER 24 HRS
remale RACE (Spacify) W1	ORCED,	1 23, 1880	75 Mon	ths Days Hours Min.
			Yrs.	
10e. USUAL OCCUPATION (Giva kind of work done during most of working life, even if OR	D OF BUSINESS	11. BIRTHPLACE (Steta or f		12. CITIZEN OF WHAT
retired) Housewife Own	Home	Snyder Co	· Fenna.	0.5.
13. FATHER'S NAME		14. MOTHER'S MAID!	N NAME	
Oliver Snyder		Mary	Burkey	
	. SOCIAL SECURITY NO.	17. INFORMANT	& ADDRESS	
(Yes, no, or unk.) (If Yes, give wer or detes of service)		- Fred He	rman Finksbu	rg. Md.
NO TO				9.
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	18. MEDICAL CER	TIFICATION		ONSET AND DEATH
1101 Box	NOUN CENI	c Carr	NOMA	2 whs.
IMINEDIATE CHOSE IN	HEAT GEILL	C CM/IL/	NONT	2
ANTECEDENT CAUSE(S) DUE TO				
DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE				
STATING UNDERLYING CAUSE LAST. DUE TO	PIOSCLEROTIC	CII DIE	-40-	VERAS
	103CLENUIIC	C.V. 11/3	EASE	TENTO
TO THE SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				
19a. DATE OF OPERATION I 19b. MAJOR FINDINGS	OF OPERATION			20. AUTOPSY?
				YES NO
21a. ACCIDENT WAS UNDERLYING 21b. PLACE (Home OR CONTRIBUTING CAUSE OF DEATH OF INJURY street, of (IF EITHER, NOTIFY MEDICAL EXAMINER)		1c. WHERE DID INJURY OC	CUR? (City or town)	(County) (State)
	INJURY OCCURRED	21f. HOW DID INJURY OC	CUR?	
Whil	e Not while			
M. at wo	ork 🗀 et work 🗀 l			
22. I hereby certify that I attended the decea	sed from £17	, 19.2.7, to A	17. 27., 1957., th	at I last saw the deceased
alive on 157. 28, 1959, and	that death occurred at.	10: P. M. from the	causes and on the date :	stated above.
SIGNATURE			DRESS Streat, city, town, stele	
Martie & Xtrapal	40 4	18 MAIN ST	NET STERSTO	W/ M/ 9/29
23. BORIAL CREMATION. I DATE THEREOF	M.D.	CREMATORY	LOCATION (City, town, or co	ounty) (State)
REMOVAL (SPECIFY)				
Burial 10-3-59	Halls Cen	etery	McKee's Hal	f Falls, Pa.
4. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR	'S SIGNATURE	ADDRESS
OCT 1'59 Serthur	Things	John R. E	vers Westmi	nster.Md.
ATF				

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10 Sentendents I. WELL SEE , EAST, ALL SEE , The Barrier County of the Coun of the select a track a passage and common property of the selection of th SHOULD BE SEEN THE REPORT OF A SECRET OF THE PARTY OF THE THE REPORT OF THE PARTY OF THE

THE COURT OF STREET

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10130

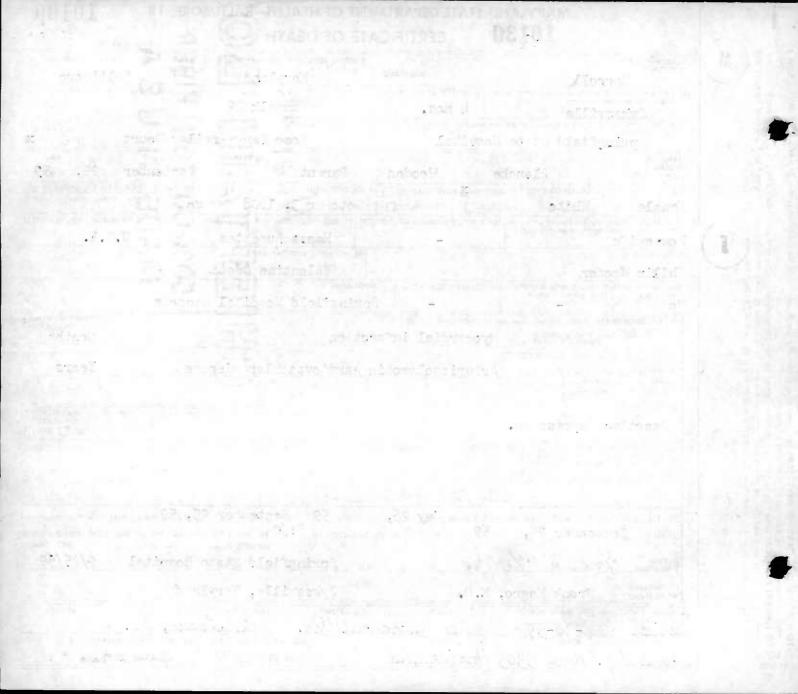
CERTIFICATE OF DEATH

Reg. Dist. No.

10109

1. PLACE OF DEATH a. COUNTY	rroll		MARYLAND	o. STATE	NCE (Where deceased	sed lived. If institut b. COUNTY		before odmis	
RURAL ond give	(If autside carporate limi neorest town) SVIIIe	ts, write c.	LENGTH OF STAY IN 16		WN (If outside corp bundalk 2	porote limits, write I	RURAL ond giv		n)
d. NAME OF HOSE OR INSTITUTION	ITAL (If not in hospital, g			d. STREET ADI		Trailer	Court	ON	SIDENCE A FARM?
3. NAME OF DECEASED (Type or print)	Fir B l at	nche	Wooden Wooden	Parent	4. DATE OF DEAT		ember	25,	Year 1959
s. sex Female	6. COLOR OR RACE White	7. MARRIED	MEVER MARRIED DIVORCED	B. DATE OF BIRTH October	3, 1908	9. AGE (In years last birthday) 50 yrs.	Months D	YEAR IF UND	7
Housewife	orking life, even if refired	done 10b. KIN	ND OF BUSINESS OR INDI	Mass	sachusett			OF WHAT	COUNTRY
13. FATHER'S NAME Philip Wo	oden			14. MOTHER'S M	entine Od	ett			
1S. WAS DECEASED EN (Yes, no, or unknown)	/ER IN U. S. ARMED FOR (If yes, give war or dates of s			Springfiel	ld Hospit		lress S		
	EATH [Enter only one co EATH WAS CAUSED BY: IMMEDIATE CAUSE (a DUE TO	Myo	for (o), (b), ond (c).] ocardial infa	arction				Mont	D DEATH
Conditions, if gove rise to couse (o), statin lying cause los	g the <u>under-</u> DUE TO)	erioscleroti				VEN IN PART I	Year	
Reactiv	e Depressio	n.					YEA 11 (1 7 (1 7 (1 7)	PERFO	ORMED?
20c. TIME OF INJU	10	20d. INJU	_ Not while fi	PLACE OF INJURY (Ho factory, street, affice b	ome, form, 20f. (C		(Co	unty)	(State
21. I certify	that I attended the	deceased , 1959 Yagn	from May 26, , and that deat	M.D. Spri	8:50AM, fran ADDRESS	n the causes an (Street, city or town tate Hosp	nd an the (date state	
22a. BURIAL, CREMAT BREMOVAL (Specif	ION, 22b. DATE THEREC		New Cathe	OR CREMATORY		Ltimore,	ar county) Md.	(Sta	rte)
23. FUNERAL DIRECTO	0 0 1	305 He	artord Rd	-	ATE SEP 2 9		ISTRAR'S SIGN		

TO HOSPITAL OR A May be retain TO FUNERAL DIRECT Page 3 shauld be d VS A1S (4) 1SM 9/SB



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VS. A15ME(5) 5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 10 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10110 a. Dist. No.

						Keg. Dist.	140.
1. PLACE OF DEATH o. COUNTY Ca:	rroll	MARY		ENCE (Where decear	sed lived. If institu b. COUNT		e before admission)
b. CITY OR TOWN (If out and give nearest town) Sykesvill	side corporate limits, write	c. LENGTH OF STAY 5yrs.5mos		OWN (If outside cor Hampstead		RURAL and gi	ive nearest town)
	or institution (if 1d State H	not in hospital, give street address		ness None			e. IS RESIDENCE ON A FARM? YES NO
3. NAME OF -DECEASED (Type or print)	First Charlott		lost lhelm Rinama	4. DATE OF DEATH	Month Septe	ember	Day Year 17, 1959
		7. MARRIED NEVER MARRIED WIDOWED DIVORCED		9,1870	9. AGE (In years last birthday) 88 yrs.	Months Da	
Housewife	(Give kind of work do ife, even if retired)	one 10b. KIND OF BUSINESS OR		E (Stote or foreign o	country)		N OF WHAT COUNTRY
13. FATHER'S NAME Daniel Whi	lhelm		14. MOTHER'S M. Char	lotte	Bes.	SOM	
15. WAS DECEASED EVER (Yes, no. or unknown) No	IN U. S. ARMED FORCE yes, give war or dates of se	CES? 16. SOCIAL SECURITY NO.	17. INFORMANT Springfi	eld Hospi	Address		
PART I. DEATH	[Enter only one could WAS CAUSED BY: MEDIATE CAUSE (a) DUE TO	Hemorrhage 1	nto left ple	ura			INTERVAL BETWEEN ONSET AND DEATH hours
Conditions, if any, gave rise to immediat (a), stating the und cause lost.	e couse	Dissecting A		he arch o	f the ac	rta	years vears
PART II. OTHER C.B.S. 9350 20c. EXTERNAL CAUSE PRIMARY OF CONTR CAUSE OF DEATH.	significant condi	tions contributing to DEATH th senile brain	BUT NOT RELATED TO THE	e terminal diseas	c reacti	/EN IN PART 1(
	WAS 20b.	DESCRIBE HOW INJURY OCCUR	RED. (Enter noture of injur	y in Port I or Part II	of item 18.)		
20c. TIME OF INJURY Hour e. m. p. m.	Month, Day, Year 9/16/ 1959	1111111	o. PLACE OF INJURY (Hor foctory, street office bl Hospital	ne, farm, 20f. (City dg., etc.)	or town)	(County	
		af the remains described auses , Accident ,			nspectian 🔀, ndetermined c		🔀, and find tha
ACTUAL SIGNATURE	ines J.	March	M.U.	DICAL EXAMINER			DATE SIGNED
EXAMINER'S NAME (Type)		Marsh, M.D.	DEPUTY MI	MEDICAL EXAMINE			9/17/59
220. BURIAL, CREMATION, REMOVAL (Specify)	9-19-	59 Itarry	RY OR CREMATORY	27d. LOCA	TION (City, town, a	60	(Stote)
23. FULLERAL DIRECTOR'S S	liston	- Herepsti	- 1 1/2 1	a. REC'D BY REGIST		STRAR'S SIGNA	

MARYLAND STATE DEFARMANT OF HEALTH-BALTIMORE TO

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		THE COURSE OF		

10112

10122

CERTIFICATE OF DEATH

	エハエワジ						Reg. Dist. N	lo.		
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)						
	Carroll		MARYLAND	o. STATE Maryland b. COUNTY Baltimore						
b. CITY OR TOWN	If outside corporate limits,	write c. LENG	OTH OF STAY IN 16	c. CITY OR TOWN (IF	outside corpore	ote limits, write RUF	RAL and give r	nearest tow	wn)	
Sykes) 4 y	3 m 15 d	Baltin	nore	3	V01-4			
d. NAME OF HOSPI OR INSTITUTION	TAL (If not in hospital, giv	e street oddress)		d. STREET ADDRESS				e. IS RE	ESIDENCE A FARM?	
Springf.	ield State H	ospital		17 S.	Robins	on Street	t		NO 🔀	
3. NAME OF DECEASED	First		Middle	Lost	4. DATE OF	Month		Day	Yeor	
(Type or print)	Ann			Schech	DEATH	Septer	nber	1	1959	
5. SEX	6. COLOR OR RACE	MARRIED N	IEVER MARRIED	B. DATE OF BIRTH	9	. AGE (In years	FUNDER 1 YE	The second second	-	
Female	EVALUATION OF	VIDOWED 🛣	DIVORCED [375	8/4 yrs.	Months Days	s Hours	Min.	
00. USUAL OCCUPATION during mast of wor	ON (Give kind of work do king life, even if retired)	ne 10b. KIND OF	BUSINESS OR INDU	JSTRY 11. BIRTHPLACE (Stote	or foreign cou	intry)	12. CITIZEN	OF WHA	T COUNTR	
House		-	-	Marylar	nd		T	J-S-A		
13. FATHER'S NAME				14. MOTHER'S MAIDEN						
	Conrad Sch	roll			Mary	Giphacold.	KRIP	P		
15. WAS DECEASED EV	R IN U. S. ARMED FORCE		ECURITY NO. 17.	INFORMANT		Addres	13			
No		-		Springfield S	State H	ospital F	Record			
18. CAUSE OF DE	ATH [Enter only one cous	e per line for (o),	(b), and (c).]				116	NTERVAL B	BETWEEN	
PART I. DE	ATH WAS CAUSED BY: IMMEDIATE CAUSE (o)	Coronar	y Occlusio	on			0	Hou		
1420.1	DUE TO							21002		
Canditions, if a	iny, which) (b)_	Arterio	sclerotic	cardiovascula	ar dise	ase		Year	ra	
gove rise to i	mmediate (450		1003	. 13	
lying couse lost.	(c)_	Broncho	pneumonia					Days	3	
Z PANT II. OT				T NOT RELATED TO THE TERM	INAL DISEASE	CONDITION GIVEN	V IN PART 1(a)			
PART II. OT Chroni psyche 20a. ACCIDENT W. OR CONTRIBUTING [IF EITHER, NOTIFY	tic reaction	drome as	sociated 1	with senile bi	rain di	sease wit	th	YES [ORMED?	
200. ACCIDENT W	AS UNDERLYING 2		W INJURY OCCURRE	ED. (Enter noture of injury in	Port I or Port I	I of item 18.}		1	1	
UF EITHER, NOTIFY	AS UNDERLYING 20 G CAUSE OF DEATH MEDICAL EXAMINER)									
3 20c. TIME OF INJUI	RY Month, Day, Year	20d. INJURY OC		LACE OF INJURY (Home, farm	n, 20f. (City o	er town)	(Count	(y)	(State)	
20c. TIME OF INJUI Hour o. m. p. m.	19	While Not of work of work		octory, street, office bldg., etc	.)					
	nat I attended the d			10E7 . Ca		. 3 50				
alive on Sep					iprembe:	١٩.5٧, ولد ٢	that I last	saw the	: decease	
alive ou Salvi	757119-5K-A9-1	, 19.22	and that death	accurred at 1:40.						
ACTUAL	2.70	1/L	2 km			et, city or town, sto			DATE SIGNI	
SIGNATURE	444 /			M.D. Springfie	old Sta	te Hospit	ial	9-	-1-59	
PHYSICIAN'S NAME (Type)	Rita S. Glah	n M D		Creis and 11	o Wass	Lara Car				
				Sykesvill		yland				
220. BURIAL, CREMATIC REMOVAL (Specify	4 4	Ta Zic. NA	ME OF CEMETERY C			ON (City, town, or	county)	(Sta		
23. EUNERAL DIRECTOR	S SICHEDINE	37. 3/	TCKEU H	EART CEM.		ERMANI	7/44/	D., M	p ,	
ONEKAL DIRECTOR	TO CONTRE	7015,0	BNIYLI	NGST	D BY REGISTRA		RAR'S SIGNAT			
remarks.	of ioselle	BA	LT0. 24	LA DE DATESE	4 39	Ciston	1 10000			

page 3 shauld be detached for use as the burial-transit permit. Then please remove touch napers. Pages 1 and 2 shauld be filled with the registrar prior to burial, cremation, ar remayal, and in any event within 72 hours after death. ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours TO HOSPITAL OR A

ofter death. Page 4

VS A15 (4) 15M 9/SS

page 3 shauld be the registrar priar

TO HOSPITAL OF may be retain

VS A1S (4) 1SM 9/S8

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10096

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY	roll		MARYLAN	0 51			d lived. If instituti b. COUNTY			re admis	sian)
	(If autside corporate limits	, write c.	LENGTH OF STAY IN 1	b c. C			rate limits, write R			prest town	n)
OR INSTITUTIO	PITAL (If not in haspital, gi N	ve street addi		/d. S	Westmi	nster				ON A	SIDENCE A FARM?
	Nursing Home	, 127 E	.Green St.		Rural					YES L	NO 🕞
3. NAME OF DECEASED (Type or print)	First Sarah		Middle Ann	Se	lost 11	4. DATE OF DEATH	Septe		23	,	Year 19 59
S. SEX		7. MARRIED	NEVER MARRIED				9. AGE (In years		-	/	ER 24 HRS
Female		WIDOWED [May		5	lost birthday) 94 yrs.	Manths	Days	Haurs	Min.
10a. USUAL OCCUPA	TION (Give kind af wark d orking life, even if retired)	ane 10b. KIN	D OF BUSINESS OR IN	DUSTRY 11.	BIRTHPLACE (State	ar foreign co	ountry)	12.CI	IZEN OF	WHAT	COUNTRY
Housewo		Ow	n home		Maryland	1		J	J.S.	A.	
13. FATHER'S NAME				14. MC	THER'S MAIDEN						
Jaco	b Sell				Elizabet	h Hes	son				
IS. WAS DECEASEDE	VER IN U. S. ARMED FORCE		IAL SECURITY NO.	INFORMA	TV		Add	ress			
(Yes, no, or unknown)	(If yes, give war or dates of ser	vice)	ne l	Ir. How	ard Mans	R #7	, Westmi	nster	n M	ולטיים	and
	EATH Enter only one cau			11 . 1101	ald made	10 11 1	, HOBOLLI	.110 061		ERVAL 8	
PART I. D 4 2 2. Canditians, if gove rise to cause (o), stating	immediate DUE TO	ge	neral	ize	and and	teri	sell	rati	is	2	yrs
Z PART II. C	the significant opin	ITIONS CON	TRIBUTING TO DEATH	BUT NOT REL	ATED TO THE TERM	MINAL DISEAS	E CONDITION GIV	VEN IN PA	RT 1(o) 1	9. WAS	AUTOPSY
Z _	8	en	lita							YES	NO 4
OR CONTRIBUTION	WAS UNDERLYING [2 NG [CAUSE OF DEATH FY MEDICAL EXAMINER)	20Ь. DESCRIB	E HOW INJURY OCCU	ED. (Enter	noture af injury in	Part I ar Par	t tl af item 18.)				
20c. TIME OF INJ Haur a. m p. m	1,	20d. INJUI While at wark	Nat while	PLACE OF II factory, street	NJURY (Home, far et, affice bldg., et	m, 20f. (City	ar town)		(Caunty)		(State
21. I certify olive on	that I attended the	deceosed , 19.59	from, ond that dec		950, 100 ed at 3 A	M, from	the couses on reet, city or town,				
PHYSICIAN'S NAME (Type)	REES	EY	ILKE	LY9,	XIA	rist	mi	nd	te	Lh	id
22a. BURIAL, CREMAT REMOVAL (Speci	TON, 22b. DATE THEREOF	22	c. NAME OF CEMETER		ORX	22d. LOCAT	TION (City, tawn,	ar caunty)		(Stat	te)
Burial	9/25/59		Baust Ceme	etery		Tyror	ne, Carro	11, 1	Mary	land	
23. FUNERAL DIRECTO	fa C. Tust	/ m-	ADDRESS		SE	D BY REGIST P 2 5 '59		STRAR'S S			
U.U.FE	ss & Son	18	neytown. My	TVIAN(1 WAIT						

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FOR STATE HEALTH DEPT TO DEPUTY DICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delegancy, please executes the certificate, writing the word "pending" in pendi in Item 18. Give Pages 1, 2, and 3 to the funeral fector. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 Noves after death.

VS. A15ME 5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 14

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
Carroll MARYLAND	Maryland Carroll						
b. CITY OR TOWN (if outside corporete limits, write RURAL and give nearest town)	c. CITY OR TOWN (If outside corporete limits, write RURAL end give neerest town)						
Manchester	X Manchester						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)	d. STREET ADDRESS e. IS RESIDENCE						
12 New Street	12 New Street YES NO						
3. NAME OF First Middle	Lasi 4. DATE Month Dey Yeer						
DECEASED (Type or print)	OF DEETH C						
LEROY ARNOLD	SHORB September 18, 1959 DATE OF BIRTH 19, AGE (In yeers IF UNDER 1 YEAR IF UNDER 24 HRS.						
7. MAKNED MEYER MAKNED A	lest birthday) Months Days Hours Min.						
Male White WIDOWED DIVORCED	11/25/l ₄ 2 16 yrs.						
Oa. USUAL OCCUPATION (Give kind of work done during most of working life, even if refired)	11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?						
student	Maryland U.S.A.						
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME						
Charles Shorb	Elsie Markle						
	INFORMANT Address						
21.8=10=2303	Charles Shorb Manchesterm Md.						
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]	INTERVAL BETWEEN						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (6) Massive subarachno	ONSET AND DEATH						
	tal aneurysm with anterior cerebral						
omt own	our around him when arrounds our and						
geva rise to immediate ceuse							
(a), stating the undarlying DUE TO							
causa last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NO	DT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(8) 19. WAS AUTOPSY PERFORMED?						
CCVI	YES 🔀 NO 🗌						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NO 2DD. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING 2DD. DESCRIBE HOW INJURY OCCURED. ()	Enter nature of injury in Part I or Part II of itam 18.)						
to a	CE OF INJURY (Home, ferm, 20f. (City or town) (County) (Stele)						
Hour a.m. P.m. 19 While Not While fact work at work	ory, streat, office bings, arc.)						
21. I certify that I took charge of the remains described above, he	ald an Autopsy X, Inspection , Inquiry , and in my opinion						
death resulted from: Natural causes X, Accident , Suic							
	CHIEF MEDICAL EXAMINER						
ACTUAL ////	ASSISTANT MEDICAL EXAMINER 😿 DATE SIGNED						
SIGNATURE JOURNAL OF	M.D.						
NAME (Type) William V. Lovitt, Jr., M.D.	DEPUTY MEDICAL EXAMINER 9/19/59						
220. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OF	Address (Street, city, town, or county) R CREMATORY 22d. LOCATION (City, town, or country) (Stete)						
REMOVAL (Specify)							
Burial 9/21/59 Manchester	Manchester Md						
23. FUNERAL DIRECTOR ADDRESS							
Edward C. Tipton Hampstead	DATE Coming St. Hance						

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VS A15 (4) 15M 9/58

10135 CERTIFICATE OF DEATH

10115 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY						Where deceased Land	lived. If instituti b. COUNTY	on: Residence Carol:	e before adm	unty
RURAL and give	l (If outside corporate limi nearest tawn) yton	its, write	c. LENGTH OF STAY IN	1ь	c. CITY OR TOWN (I		ote limits, write R	URAL ond g	ive nearest to	iwn)
d. NAME OF HOSE OR INSTITUTION Henryt	PITAL (If not in hospital, good State Ho	spita	address)		d. STREET ADDRESS River				ON	RESIDENCE A FARM?
3. NAME OF DECEASED (Type or print)	Th:	omas	Middle		Simms	4. DATE OF DEATH	Septer		Day 7	Year 1959
5. SEX Male	6. COLOR OR RACE Negro	WIDOWE			farch 8, 18	883	9. AGE (In years lost birthdoy) 70 yrs.		YEAR IF UN Days Hau	
Oa. USUAL OCCUPAT during most of w Day	TION (Give kind af work orking life, even if retired baborer	done 10b.	KIND OF BUSINESS OR I	try	11. BIRTHPLACE (SIG	ote or foreign co Land	untry)		U. S.	
3. FATHER'S NAME James	Simms			1	4. MOTHER'S MAIDEN	N NAME ie Jinki	ins			
(Yes, no, or unknown)	VER IN U. S. ARMED FOR (If yes, give war ar dates of s		Unknown		rmant Chomas Simi	ms	Fede:		rg, Md	
Conditions, if gove rise to couse (o), stotin lying couse los	immediate DUE TO	Fa:	r advanced	pulr	nonary the	c. with	cavitat	tion		
PART II. O		-	ONTRIBUTING TO DEATH	BUT NO	T RELATED TO THE TER	RMINAL DISEASE	CONDITION GIV	VEN IN PART	PER	S AUTOPSY FORMED?
	WAS UNDERLYING A NG CAUSE OF DEATH FY MEDICAL EXAMINER)	20b. DESC	RIBE HOW INJURY OCCI	URRED. (Enter nature of injury	in Port I or Port	II of item 18.)			
20c. TIME OF INJU Hour o. m	10	ar 20d. IN While at wark	_ Nat while	e. PLACE foctor	OF INJURY (Home, for, street, office bldg.,	etc.)			ounty)	(Stote
ACTUAL SIGNATURE	odgars (n.m	ed fram August 9 , and that de conformation ulans, Supt	eath a	ccurred at 10	Address (Street	the causes and reet, city or town, m., Maryli Hospita	nd an the stote) and	date stat	ed abave ATE SIGNE 59
Burial	Sept.10,		St. Paul (tery	Near	ION (City, town, Federals	sburg,	Maryl	tote) and
23. FUNERAL DIRECTO	otom and Son	, Fede	ADDRESS eralsburg, M	aryl	and PATE	EC'D BY REGIST		STRAR'S SIG		

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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r death. Page 4

VS A15 (4) 15M 9/5B

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

10117

	10187		CERTITION	TIE OI DEAL			Reg. Dist.	No.	
1. PLACE OF DEATH o. COUNTY	Carroll		MARYLAND	2. USUAL RESIDENCE (Vo. STATE	Where deceased	lived. If institution b. COUNTY		before admi	/
b. CITY OR TOWN RURAL and give to Sykesvi	If outside corporate limits, earest town)		TH OF STAY IN 16	c. CITY OR TOWN (I		ote limits, write R	URAL ond give	nearest tow	rn)
d. NAME OF HOSPI OR INSTITUTION	TAL (If not in hospital, give			d. STREET ADDRESS 6500 Let	mert Av	enue		ON	A FARM?
3. NAME OF DECEASED (Type or print)	First Myr	ta	Middle Isabel	Snider	4. DATE OF DEATH	Septe		Day 7,	Year 1959
5. SEX Female	W 99 4 4	MARRIED N	DIVORCED	B. DATE OF BIRTH July 23, 18	378	9. AGE (In years last birthday) 81 yrs.	Months Da		T
Nurse	ON (Give kind of work dor king life, even if retired)	ne 10b. KIND OF	BUSINESS OR INDU	STRY 11. BIRTHPLACE (Stor		untry)		U.S.A	
13. FATHER'S NAME				Sara Mi					
Albert Sn: 15. WAS DECEASED EV (Yes, no, or unknown) No	ER IN U. S. ARMED FORCE (If yes, give war or dates of servi			nformant oringfield He		Records	ress		
	immediate (Arter		ic heart disc	ea se			Yea:	D DEATH
V.	HER SIGNIFICANT CONDIT			NOT RELATED TO THE TER C heart disc			EN IN PART 1	o) 19. WAS PERF YES	AUTOPS ORMED?
U (IF EITHER, NOTIFY 20c. TIME OF INJU Hour o. m. p. m.	MEDICAL EXAMINER)			ACE OF INJURY (Home, fo		or town)	(Cou	nty)	(Sto
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)	hat I attended the deptember 6, Agustin de	1259 del 1Campo,	Camp M.D.	Sykesvil	A M, from I ADDRESS (Sir eld Stat le, Mary	he causes an eet, city or town, te Hospi	d an the d state) tal	ate state	
220. BURIAL, CREMANI REMOVAL (Specify 23. FULLERAL DIRECTOR	8-9-59	9 4	DRESS	de Cem.	C'D BY REGISTI	Tallo.	STRAR'S SIGNA	ATURE	P
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MARVIAND	CTATE	DEDADTMENT	OF HEALTH BALTIMODE TO	c
THOM	SIMIL	DEIARIMEITI	OF HEALTH—BALTIMORE, 1	ů

		101	m 4.		PICA	ATE OF DEAT	ne,F.D. H	•)	Reg. Dist.	No.	10	118
1. PLACE OF DI a. COUNTY		arroll	0.0-	MAR	YLAND	2. USUAL RESIDENCE (V		ed lived. If instituti b. COUNTY	on Residence	befare	odmiss	ion)
RURAL and	give neo	outside carporate fimi rest tawn) -Mt. Airy		6 Vrs		cacity or town (if		orate limits, write R	URAL ond giv	e near	est town	1)
d. NAME OF OR INSTIT	HOSPITA UTION	L (If not in hospital, g	ive street	address)		d. STREET ADDRESS				•	ON A	FARM?
3. NAME OF DECEASED (Type or prin))	BER T	st	Middle O •	•	SWARTZ	4. DATE OF DEATH	Mor SEP	- 0	Doy		Yeor 19 59
5. SEX male		6. COLOR OR RACE White	7. MAR	RIED NEVER MARR		8. DATE OF BIRTH 7-7-1892		9, AGE (In years last birthday) 67 yrs.	Manths D		F UNDE Haurs	Min.
Ordina				ept. of		STRY 11. BIRTHPLACE (Stor	le ar fareign	country)		S.		COUNTI
13. FATHER'S NA		sse Swart	Z			Clara Br		k				
15. WAS DECEA (Yes, no, or unknow NO		IN U. S. ARMED FOR yes, give wor er dates of s	prvice)	. SOCIAL SECURITY NO 78-32-890		Mrs. Lilli	an Sw	artz,	same			77
	T I. DEAT	H [Enter only ane co H WAS CAUSED BY: IMMEDIATE CAUSE (a DUE TO	Ce	rebral Wa		lar Thromb	osis			INTER ONSE	TAND	TWEEN
Condition gave ris cause (o), lying cau	e to im stating th	mediate (,									
¥ L		R SIGNIFICANT CON			EATH BUT	NOT RELATED TO THE TER	MINAL DISEA	SE CONDITION GIV	VEN IN PART I	11	PERFO	AUTOPSY RMED?
	ENT WAS BUTING I NOTIFY A	UNDERLYING CAUSE OF DEATH MEDICAL EXAMINER)	20b. DE	SCRIBE HOW INJURY (OCCURRE	D. (Enter nature of injury in	n Part I ar Pa	rt II of item 18.)		5		
20c. TIME O	F INJURY o. m. p. m.	Manth, Day, Ye	20d. While at wa			ACE OF INJURY (Home, for ctary, street, affice bldg., e		ly or tawn)	(Co	unty)		(State
21. I cer alive an actual signaturi	9/				death	18 , 19 , to accurred of 1:4	Q BM, fra ADDRESS (m the causes of Street, city or town,	and an the		state	
PHYSICIAN	's na-	ata B 1	f	- N D								

Damascus. Maryland

220. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, tawn, or county)

(State)

23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,

Fort Lincoln
Winfield, Md.

Bladensburg, Md.

240. REC'D BY REGISTRAR
SEP 2 2 '59

Culling & Huse DATE

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the attending physicion and completely filled within 72 hours offer JOR: After this certificate has been signed by detoched for use as the burial-transit permit. the registrar prior poge 3 should TO FUNERAL

after death. Page

requires that the death certificate be executed within 24 haurs

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TO HOSPITAL OR

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VS A15 (4) 15M 9/5B

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 10139

CERTIFICATE OF DEATH

Reg. Dist. No.

10119

0	PLACE OF DEATH COUNTY CAPTON	MARYLAND	2. USUAL RESIDENCE (Who o. STATE Maryland	ere deceased tived. If instituti b. COUNTY	on: Residence before admission) Battimore
	CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b		utside corporate limits, write R	URAL and give nearest town)
-	vkesville d. NAME OF HOSPITAL (If nat in haspital, give street OR INSTITUTION	8 days	d. STREET ADDRESS	22	e. IS RESIDENCE ON A FARM?
9	Springfield State Hospits	1	2939 Liberty	Parkway	YES NO
1	NAME OF First DECEASED (Type or print)	Middle	Last	4. DATE Mor	
5. 5	W11 101011	Lenonard	Vogel Jr. B. DATE OF BIRTH	9. AGE (In years	6 1959 IF UNDER 1 YEAR IF UNDER 24 HRS.
J. J	male white Widow	The Cartest was a second	5/17/18	last birthday)	Months Days Haurs Min.
10a.	. USUAL OCCUPATION (Give kind of work done 10b. during most of working life, even if retired)	KIND OF BUSINESS OR INDU	STRY 11. BIRTHPLACE (State	or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	Steel Worker 5	TEBL MECK	The second secon		U.S.A.
13.	FATHER'S NAME		14. MOTHER'S MAIDEN N	IAME	
	Wilbur Lennard Vogel, Sr.		Esther Ry		
	WAS DECEASED EVER IN U. S. ARMED FORCES? 16. no, or unknown) (If yes, give wer or dates of service)		NFORMANT	Baltimor	
	ves 1940- 41	68-18-6802 W	fe- Irene Vog	el 2939 Liber	ty Parkway
	Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost.	cinoma of Pane Liver a nd Lun	es with me w	1802818	months
CATION	PART II. OTHER SIGNIFICANT CONDITIONS				VEN IN PART 1(o) 19. WAS AUTOPSY PERFORMED? YES NO
CERTIF	20a. ACCIDENT WAS UNDERLYING A 20b. DES OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	CRIBE HOW INJURY OCCURRE	D. (Enter nature of injury in F	Part I or Port II af item 18.)	
MEDICA	20c. TIME OF INJURY Month, Doy, Year 20d. I Haur a. m. 19 While p. m. 19	Not while fo	ACE OF INJURY (Hame, farm ctory, street, office bldg., etc.		(County) (State)
	21. I certify that I attended the decease alive an 9-6- 195 ACTUAL CIGNATURE DESCRIPTION DE				
	PHYSICIAN'S Agustin del Camp		Sykesville		
15	BYRIAL, CREMATION, 22b, DATE THEREOF 9955	22c. NAME OF CEMETERY O	APPAIRVIEW	22d. LOCATION (City, town,	or county) (Stote)
23.	FUNERAL DIRECTOR'S SIGNATURE BOOK	And Address Audula	1 14 DATE SE		STRAR'S SIGNATURE

and the tensile impound to be with A CONTROL OF A CON and the little feet and Leath Electrical Little Description albertades detre appropriate to manifestale the 81/2/10/10 furthern state fire the length of beauties. They was suck to the . hand war, a little water to the William of the Aller of The first want for the party and a start - 1811. I The second of th ofter death. Page

requires that the death certificate be executed within 24 hours

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10140 LERTIFICATE OF DEATH

MARYLAND

10120

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Reg.	Dist.	No.			

 USUAL RESIDENCE (Where deceosed lived. If institution: Residence before admission)
 STATE
 b. COUNTY b. COUNTY

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PLACE OF DEATH

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y the hospitol ar attending physician.

**TOR: After this certificate has been signed by the detached for use as the burial-transit permit. Then

TO HOSPITAL C.S. A may be retoin TO FUNERAL DIRECT page 3 should be of the registror prior the registron p VS A1S (4) 1SM 9/SB

Ca	rroll		MARYLAN	ND .	Mar	vland	b. COUNTY	Ca	rrol	1	
RURAL ond give	(If outside corporate lim nearest town)	its, write	c. LENGTH OF STAY IN	1b c.	CITY OR TOWN		orote limits, write f			arest town)
	PITAL (If nat in haspital,	give street a	ddress)	1 d	STREET ADDRES						IDENCE FARM?
3. NAME OF DECEASED (Type or print)	Fie	rst	Middle		Last	4. DATE OF DEATH	Mor		Do		Year
	Effie	17	Viola		agner	DEATH	OC DIE	ember	12		19 59
s. sex	White	VIDOWEE	ED NEVER MARRIED [e 26. 18	81	9. AGE (In years last birthdoy) 78 yrs.		Days	Hours	Min.
10a. USUAL OCCUPAT	ION (Give kind of work orking life, even if retired	done 10b. K	IND OF BUSINESS OR IT				country)	12.CI	TIZEN O	FWHATC	OUNTRY
Housewo					Marylan	d		U.	S.A.		
13. FATHER'S NAME				14.	MOTHER'S MAID						
117477	dam II Was				Manne	Wenless of	-				
Will S WAS DECEASED EV	Tam H. Wag		OCIAL SECURITY NO	INFORM	Mary	Unknow	Add	ress			
(Yes, no, or unknown)	(If yes, give war ar dates of s		OCIAL SECONIT IVO.								
no			none	Mr.	William	Segafoo	se, Unio	ntown	, Md		
	EATH [Enter only one co	ouse per line	fas (a), (b), and (c).]	1	0	0-1				ERVAL BE	
PART I. DI	EATH WAS CAUSED BY: IMMEDIATE CAUSE (c	, (lancis	1 1	in dr	llich	ne		2	un	2-
1599	DUE TO		, , , , , , , , ,							1	7
7 9 9 7		1 - 7									
Conditions, if)(
cause (a), statin											
lying couse los	<u>t.</u>) (c	=)									
PART II. O	THER SIGNIFICANT CON	DITIONS CO	ONTRIBUTING TO DEATH	BUT NOT R	ELATED TO THE TO	ERMINAL DISEA	SE CONDITION GI	VEN IN PA	RT 1(o)	PERFO	AUTOPSY RMED?
OR CONTRIBUTION (IF EITHER, NOTIF	VAS UNDERLYING [] IG [] CAUSE OF DEATH Y MEDICAL EXAMINER)	20b. DESC	RIBE HOW INJURY OCCU	URRED. (Ente	er nature of injury	y in Part I or Pa	ort II of item 18.)				94
20c. TIME OF INJU	10	While	JURY OCCURRED 200 Not while at work	e. PLACE OF factory, st	INJURY (Home, treet, office bldg.	form, 20f. (Ci	ty or town)		(County)		(Stote
₹ p. m		ut work		,	171	(0 6	10 1 0	0)			
21. I certify	that I attended the	decease	d from Jau	1 /	19-19, to_	53/01	195	that I I	ast say	w the d	ecease
alive an	Jagu - 14	190	1_, and that de	eath accu	rred at	M fram	the causes ar	nd an th	ne date	e stated	abav
/	111 1	2 . /	1.0				Street, city or town,				E SIGNE
ACTUAL SIGNATURE	10/	N	Legg	M.D:	llu	iau	13ru	18	(9-15	1-50
PHYSICIAN'S NAME (Type)	TIN	LE	99		U	esei	11/3ri	My	_	7	Rid
220. BURIAL, CREMAT REMOVAL (Specif	(y)	OF	22c. NAME OF CEMETER				ATION (City, town,			(Stot	e)
Burial 23. FUNERAL DIRECTO	9/15/59		Haugh's Ce	meter			Midway,	ISTRAR'S S			
Herev	4 - To 12	/	WDDKESS			REC'D BY REGIS					
C.O.Fuss	& Son	Tane	evtown, Mary	rland	DATE	SEP 1 6	22 (1	rthun S	Tha	ud	
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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10121 CERTIFICATE OF DEATH 10097 Rea Dist No. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. COUNTY b. COUNTY MARYLAND Maryland Carroll County Carroll b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) RURAL and give nearest town) Westminster Westminster d NAME OF HOSPITAL (If not in hospital, give street oddress) d STREET ADDRESS e IS RESIDENCE OR INSTITUTION ON A FARM? YES NO 265 E. 265 E. Main St. Wain St. NAME OF 4. DATE Fire Middle Lost Month Day Year OF (Type or print) I95919 Santa Isth George Rvla Wagner 6. COLOR OR RACE 7. MARRIED TO NEVER MARRIED 5. SEX 9. AGE (In years lost birthdoy) IF UNDER LYEAR IF LINDER 24 HPS 8. DATE OF BIRTH Months Days Hours WIDOWED | DIVORCED T 39 10o. USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR INDUSTRY 11, BIRTHPLACE (Stote or foreign country) 12 CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) Maryland TI-S.A. owner operator of service station 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME Charles W. Wagner Margaret M. Grabbs 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT 265 E. Main St. G. Wagner W_W_II ves Westminster Md 18. CAUSE OF DEATH [Enter only one couse per ling for (o), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (6) DUE TO Conditions, if ony, which gove rise to immediate DUE TO coese (o), stating the underlying couse lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19, WAS AUTOPSY CATION PERFORMED? YES NO P

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)

20g. ACCIDENT WAS UNDERLYING CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month.

Day, Year 20d. INJURY OCCURRED While Not while

of work

of work

20e. PLACE OF INJURY (Home, farm, 20f. (City or town) factory, street, office bldg., etc.)

(County)

21. I certify that I attended the deceased from 195 Z that I last saw the deceased and that deoth occurred at 5 15 1 M, from the couses and on the date stated above. ADDRESS (Street, city or town, stote) DATE SIGNED

ACTUAL

Chepko.

(Stote)

PHYSICIAN'S NAME (Type)

o. m.

p. m

220. BURIAL, CREMATION, 225. DATE THEREOI Sept. I6th 59

22c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial Cem22d. LOCATION (City, town, or county) Finksburg.

(Stote) Carroll Co. Md

23. FUNERAL DIRECTOR'S SIGNATURE

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

REMOVAL (Specify)

254E. Main St. Westminster

15M 9/55

0 VS A15 (4)

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0	310	S	page 3 should be detoched far use as the burial-transit permit. Then please remove carbon papers. Poges 1 and 2 should be filed with	pr.	
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TO HOSPITAL OF ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 haur after death. Page 4	may be retail by the haspital ar ottending physician.	TO FUNERAL DESCIOR: After this certificate has been signed by the attending physician and completely filled in by The funeral director,	Q.	the registrar prior ta burial, crematian, or removal, and in any event within 72 faurs after death.	

VS A1S (4) 1SM 9/S8

o. COUNTY	rroll		MARYLAND	o. STATE	Maryland	h	If institution.	Carro		admission)
b. CITY OR TOWN (I RURAL and give no Sykesvi			yrs.7mos.1	1)	TOWN (If outside Manchest		its, write Rl	JRAL ond gi	ve neares	t town)
OR INSTITUTION	AL (If not in hospitot, g			d. STREET	None					IS RESIDENCE ON A FARM? ES NO T
3. NAME OF DECEASED (Type or print)		ra	Middle V •	Warner		ATE OF DEATH	Sept	ember	Doy 3,	Year 19 59
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MARRIED TO	8. DATE OF BIRT		lost	(In years birthdoy) yrs.			UNDER 24 HRS.
10a. USUAL OCCUPATIOn during most of work None	DN (Give kind of work or king life, even if retired)	lone 10b. KIND	OF BUSINESS OR IND		LACE (Stote or for	eign country)			S.A.	HAT COUNTRY?
13. FATHER'S NAME George L.	Warner				MAIDEN NAME ly Heinde	1				
1S. WAS DECEASED EVE (Yes, no, or unknown)	R IN U. S. ARMED FOR (If yes, give wor or dates of se		L SECURITY NO.	INFORMANT Springfie	eld Hospi	tal Re	Addr			
Conditions, if or gove rise to it couse (a), stoting lying couse lost. PART II. OTI- Psychosi 20a. ACCIDENT WA	mmediate the under (c) HER SIGNIFICANT CONI S with orga	Carc: ope:		eft breas	otheterminale system.	was re	DITION GIV		Yea	
20c. TIME OF INJUR Hour o. m. p. m. 21. I certify th alive on Sep	at I attended the	while of work of deceased from 1959	on November and that dear		B, (Septem 10:10R,	mber 3,	, 1 52 ,	that I las		
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) 220. BURIAL, CREMATIO BEMOVAL (Specify)		Magro, M		Syl	cingfield cesville,		and		100/	9/4/59 (Stote)
23. FUNERAL DIRECTOR	STGNATURE	San	ADDRESS Rock	R.	24a. REC'D BY	REGISTRAR 9 '59		TRAR'S SIG		a. Trice

TUTAL CERTIFICATE OF SEATH shiple are and all some and inspositifi Forest and the second a responding the state of the state of of an area are that a deposit of the properties in . 777 - 117 317 Personal and the control of the control of the control of the control of Marie Land - Const. Control of the Land Control of the state of the s Riving a famoli of the language of the languag bee world, allevening A STANK CONSOLETA A SHEET A The second second

TENDING PHYSICIAN: The law requires that the death certificate be

TO HOSPITAL O

VS A15 (4) 15M 9/5B

executed within 24 haurs

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10123

10142

Reg. Dist. No.

	. PLACE OF DEATH o. COUNTY Carroll		MARYLAND	2. USUAL RESIDENCE (V o. STATE Maryland	Where deceosed	b. COUNTY			ission)
1	b. CITY OR TOWN (II RURAL ond give ne Sykesyill		c. LENGTH OF STAY IN 16 2yr.7mo.13days	c. CITY OR TOWN (III		rote limits, write R	URAL ond	give nearest to	wn)
	d. NAME OF HOSPIT. OR INSTITUTION	AL (If not in hospital, give street	address)	d. STREET ADDRESS 3003 King		Drive	700	ON	ESIDENCE A FARM?
3	NAME OF DECEASED (Type or print)	First Charles	Middle Encelle	lost Wayman	4. DATE OF DEATH	Mon	ember	Day 2	Year 19 59
5	. sex	6. COLOR OR RACE 7. MARI	RIED NEVER MARRIED	B. DATE OF BIRTH JaJuney 10.	1879	9. AGE (In years last birthday) 80 yrs.		1 YEAR IF UN Days Hour	DER 24 HRS.
	Oa. USUAL OCCUPATION during most of work Draftsman 3. FATHER'S NAME	N (Give kind of work done 10b. ing life, even if retired)	KIND OF BUSINESS OR INDUS	West Vin	rginia			ZEN OF WHAT	COUNTRY?
1	Thomas E.	Warman		Alice Br					
1	5. WAS DECEASED EVER	R IN U. S. ARMED FORCES? 16.	SOCIAL SECURITY NO. 18	NFORMANT Springfield		al Recor			
	Conditions, if or gave rise to in cause (a), stating lying couse lost.	DUE TO ny, which mediate the under- (b) B1 (c) (c)	ute prostatic s	rative nephr				interval onset an week	D DEATH
101010101010	20g. ACCIDENT WA	ER SIGNIFICANT CONDITIONS WITH CLS. BURDERLYING 20b. DES CAUSE OF DEATH MEDICAL EXAMINER	CONTRIBUTING TO DEATH BUT METADOLISM Chotic reaction CRIBE HOW INJURY OCCURRED	le .			enile	T 1(o) 19. WA: PERI YES	S AUTOPSY ORMED?
10000	20c. TIME OF INJURY Hour o.m. p. m.	Y Month, Day, Year 20d. I 19 While of wor	Not while fac	ACE OF INJURY (Home, fa tary, street, affice bldg., e		or town)	(0	County)	(State)
	alive an September of September	gustin del Cam N. 22b. DATE THEREOF URIAL 9/5/59	Care bo Care bo Oo, M.D. 22c. NAME OF CEMETERY O WOOdlawn Cem	accurred at 2:451 M.D. Springs Sykesvi R CREMATORY etery	ADDRESS (SH	the causes an ireet, city ar town, tate Hosparyland TION (City, tawn, bont, West	od an the state) pital ar county) c Virg	9/3	
3	RALIM OUR CO	UMPAREY, INC.	SILVERSS SPRING,	MD.	C'D BY REGIST		STRAR'S SIC	GNATURE	

HTARGE STANDARD STAND

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Name - Annie	rat (at itwants)	nd Cemon, E.D.	nitrati N. D. 1801
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CERTIFICATE OF DEATH

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								Kag. Dis	. 110.	
1. PLACE OF DEATH o. COUNTY	Carroll		MARYI	- 11	O. STATE Maryl		d lived. If instituti b. COUNTY		e before admiss	sion)
RURAL and give no	If outside carporote limi eorest town) ville (Rura		c. LENGTH OF STAY		c. CITY OR TOWN (IF		prote limits, write F	RURAL and gi	ve nearest town	n)
d. NAME OF HOSPIT	TAL (If not in hospital, g	ive street o	ddress)	a	d. STREET ADDRESS			70/-6	e. IS RES	SIDENCE A FARM?
Spring:	field State	Hosp	ital		5 N.	East 1	Avenue		YES] NODE
3. NAME OF DECEASED (Type or print)	Paul		Matil	da	Wiegand	4. DATE OF DEATH	Mor Sept	ember		Year 1959
5. SEX	6. COLOR OR RACE	7. MARRI	ED NEVER MARRIE		DATE OF BIRTH	7 007	9. AGE (In years lost birthdoy)		YEAR IF UND	ER 24 HRS. Min.
Female 10c. USUAL OCCUPATION					October 5,		77 yrs.	12. CITI	ZEN OF WHAT	COUNTRY
during most of work House	king life, even if retired Swife		Aleme		Maryla	nd			U.S.A.	COOMIN
13. FATHER'S NAME		263			14. MOTHER'S MAIDEN	NAME				
	Karl Ger				Ma	ria Le				
15. WAS DECEASED EVE {Yes, no or unknown}	If yes, give war or dates of s		14-65-790	1	pringfield	State	7	Recor	d	
	ATH [Enter only one co		for (a), (b), and (c).]						INTERVAL BE	TWEEN
422.1	DUE TO			tia A	rterioscler	otic C	ardiovas	cular	deys years	3
Canditions, if a gave rise to i	mmediate				Disease					
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OR CONTRIBUTING	MEDICAL EXAMINER)	2001 0200	MBE HOW WOOM O	.commes,	terrer motore at impory in				*	
20c. TIME OF INJUR Hour o. m. p. m.	RY Month, Day, Yea	While	JURY OCCURRED Not while of work	20e. PLAC foctor	E OF INJURY (Home, farr ry, street, office bldg., etc	m. 20f. (City	y or town)	(Co	ounly)	(State)
21. I certify the alive on Septimental Signature	konsta	decease 1959	d fram July 1	death o	., 19 59, 1050 ccurred all 0:00	_AM, frai	m the causes of treet, city or town,	and on the	ost saw the e date state o	deceased ed abave ATE SIGNEI 4/59
	Constantin		M. D.		Syke	sville	Maryla	nd		
220. BURIAL, CREMATIO REMOVAL (Specify)	9-5-	59	22c. NAME OF CEME	TERY OR O	REMATORY	Tel. LOCA	TION City, town.	or county)	16 (Stat	ml
23. FUNERAL DIRECTOR	's SIGNATURE	let.	ADDRESS	ille,	Mel DATESE	P 9 '5	0 -	STRAR'S SIGI		

e funeral directar, should be filed with ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. Page 4 **DEUNERAL** CIOR: After this certificate has been signed by the attending physician and campletely filled in page 3 should be detached for use as the burial-transit permit. Then please remave carbon papers. Pages 1 and the registror prior to burial, cremation, ar remaval, and in any event within 72 haurs after death. by the haspital ar attending physician. may be retor page 3 shoul TO HOSPITAL VS A15 (4) 15M 9/SS

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CERTIFICATE OF DEATH

Reg. Dist. No. 10125

1. PLACE OF DEATH O. COUNTY	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institute of STATE b. COUNT	
b. CITY OR TOWN (If outside corporate limits, write c. RURAL and give nearest town)	6 Mose	c. CITY OR TOWNAIT outside corporate limits, write	RURAL and give nearest town)
ONAME OF HOSPITAL (If not in hospital, give street address I was the st	oul	/ d. STREET ADDRESS	Is residence on a farm? YES NO A
3. NAME OF DECEASED (Type Sprint) EDWARD -	Middle _	WISE 4. DATE OF DEATH SOP	onth 8 Day Year 1939
5. SEX 6. COLOR OR RACE 7. MARRIED WIDOWED	NEVER MARRIED	Sept 4-1867 9. AGE (In year loubbirthday)	Months Doys Hours Min.
10a. USUAL OCCUPATION (Give kind of work done 10b. KINI duping) most of working life, even if retired)	of Business OR IND	USTRY 1. BIRTHPLACE (Stole or foreign country)	12. CITIZEN OF WHAT COUNTRY
13. FATHERIS NAME Leorge L Wi	il	14. MOSHER'S MAIDEN NAME Eva M Kole	ic
IS. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOC (Yes, no. or unknown)	-03-63/1 V	no blueve Miller -	Hampsterd Wd
18. CAUSE OF DEATH [Enter only one couse per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)	(c). (b). ond (c).]	myrcandites.	INTERVAL BETWEEN ONSET AND DEATH
Conditions, if ony, which gove rise to immediate couse (a), stating the underlying couse lost. DUE TO DUE TO (b) DUE TO	wellst	1- Coulis Voscular De	gial .
PART II. OTHER SIGNIFICANT CONDITIONS CONT	TRIBUTING TO DEATH BU	IT NOT RELATED TO THE TERMINAL DISEASE CONDITION G	IVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED?
OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	E HOW INJURY OCCURE	RED. (Enter nature of injury in Port I or Port II of item 18.)	
Hour o.m. While	Not while of work	PLACE OF INJURY (Home, form, 20f. (City or town) octory, street, office bldg., etc.)	(County) (State)
21. I certify that I attended the deceased for alive on 1957. ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)		h accurred at SIND M, from the causes ADDRESS (Street, city or town M.D. Hamps + EAD	
Asimal 9-10-59	c. NAME OF CEMETERY	esburg Carroll	ed ma
23. TONERAL DIRECTOR'S SIGNATURE.	address stead	1111	GISTRAR'S SIGNATURE

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 e funeral director. CTOR: After this certificate has been signed by the attending physicion and completely filled in a detached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 11 to burial, cremation, or remayal, and in any event within 72 hours, ettag death. the registrar priar ta burial, cremation, or remaval, and in any event within 72 haurt page 3 should be detached for use as the burial-transit permit. TO HOSPITAL O may be retain TO FUNERAL VS A15 (4) 15M 9/55

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